CHS Treatment Manual

Bloomington's Outpatient & Intensive Outpatient Treatment Model

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Table of Contents

Acknowledgments, Disclaimer, and Contact Information v

I. Introduction 1

The Problem 1
Description of the Adolescent Treatment Models Study 1
Purpose, Development, and Organization of This Manual 3

II. Overview of the Treatment Model 5

History of the Program 5
Area Served 5
Facilities, Accreditation, and State Requirements 6
Target Population Characteristics and Demonstrated Needs 6
Substance Abuse Prevalence 9
Conceptual and Theoretical Framework 9
Overview of the Treatment Process 10

III. Recruitment, Assessment, and Treatment Placement 15

Recruitment Activities 15
Assessment and Placement Process 16
Special Situations 18
Admission Appointment 20
Screening and Admission Statistics 21

IV. Overview of Treatment Components 23

Individual Work with the Adolescents 23
Adolescent Skills Groups 23
Adolescent Counseling Groups 23
Family Night 24
Family Counseling Sessions 24
Treatment Goals and Change Mechanisms 25
Collaborating with Others 34
Addressing Critical Treatment Issues/Special Services 40
Evaluation of Adolescent Progress in Treatment 47
Example Master Treatment Plan 48
Example Outpatient Group Schedule 55
Example Weekly Checksheet 56

V. Individual Work with the Adolescent 57

Format for Individual Sessions 57
When Individual Sessions Are Provided 57
Session Structure 58
Individual Sessions During Different Phases of Treatment 58
Individual Session Topics and Themes 60
Descriptions of Different Types of Individual Sessions 60

VI. Skills Groups Work with the Adolescent 85

Format of Skills Groups 86
Types of Skills Groups 87
Preparing for and Leading a Skills Group 89
Skills Group Activities 89
Attention to Individual Needs During a Skills Group 90
Ending a Skills Group 90

VII. Group Counseling with the Adolescent 91

Format for Counseling Groups 91
Beginning the Group 92
Keeping the Group on Target 94
Ensuring Full Participation 95
Types of Counseling Groups 95
Ending the Group 95

VIII. Family Night 97

First Hour of Family Night (Informational Sessions) 97
Second Hour of Family Night (Multifamily Counseling Sessions) 101
Ending Family Night 102

IX. Family Counseling 103

Format for Family Counseling 103
Admission Sessions 103
Referring to Other Community Supports 104
Master Treatment Plan Review Family Sessions 105
Homework Assignments 105
Rebuilding Trust and Addressing Peer Relationships 105
Summary 109

X. Troubleshooting: Strategies for Common Clinical Problems 111

Late for Sessions 111
Missed Groups or Individual Sessions 112
Unwillingness to Attend AA/NA/CA Meetings 112
Glorifying Substance Use 113
Attending Treatment While Under the Influence 114
Low Motivation/Lack of Commitment 115
Negative Attitude 116
Crises 118
Treating Co-Occurring Disorders 120

XI. Transfer and Discharge Process 123

Determining Readiness for Transfer and Discharge 123
Transferring an Adolescent Due to Progress or Lack of Progress 124
Discharging an Adolescent Due to Progress or Lack of Progress 125
Discharge Planning 126
Successful Discharge Party and the Final Family Session 126

XII. Staff Characteristics and Requirements 129

Outpatient Coordinator 130
Primary Counselors 130
Latino Youth Interventionist 131
Outpatient Counselor Assistant 132
Case Manager 132
Medical Staff 134
Support Staff 134

XIII. Clinical Supervision 139

The Role and Importance of Supervision 139
Training New Staff Members 140
Individual Supervision Sessions 140
Informal Supervision 144
Supervisor Observation 144
Staff Meetings 145

XIV. Staff Training 147

New Staff Member Training 147
Appraising Staff and Determining Competency 148
Maintenance Training 149
Professional Development, Licensure, and Certification 150

XV. Implementing the CHS Program 153

Budget and Revenue Sources 153
Facility Needs 154
Marketing the Program 154
Staff 156
Staff Meetings 157
Scheduling 157
Setting Program Goals 157
Importance of Quality Improvement Activities 158
Challenges for Replication/Barriers to Service 158

References 161

APPENDIX A: Key Terms

APPENDIX B: Job Descriptions for Key Staff

APPENDIX C: Materials for Skills Groups

APPENDIX D: Outlines for Family Night Sessions

APPENDIX E: Clinical Forms

APPENDIX F: Youth Outpatient Services Handbook

APPENDIX G: Additional Resources

Acknowledgments, Disclaimer, and Contact Information

This manual provides an overview and detailed information about the Chestnut Health System (CHS) adolescent Outpatient and Intensive Outpatient Programs in Bloomington, Illinois. These programs have been designed for adolescents who meet the American Society of Addiction Medicine's criteria for Level I or Level II treatment placement (PPC-2R; ASAM, 2001). This manual is a product of the Adolescent Treatment Models (ATM) grant (grant no. KD1 TI11894) that was funded by the Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS).

The authors of this manual have attempted to pull together thorough descriptions of all aspects of the program to allow replication. We acknowledge that this work builds on the shoulders of many former and current CHS employees who have developed this program over its 15-plus-year history. Since CHS is an eclectic program and through the years has employed staff members with various backgrounds, the ideas and work of many people have been incorporated into the approach. We have attempted to acknowledge the source of other's ideas or any copyrighted work that has been used in designing sessions. We apologize if we have inadvertently left out any pertinent references. We also want to make clear that the program is not static. The program evolves as it responds to many influences, including new staff who bring different types of expertise (e.g., art therapy), new knowledge about effective procedures/interventions gleaned from the professional literature, new funding opportunities, and findings from evaluation and quality improvement efforts.

Some of the prior Chestnut Health Systems employees who we would like to acknowledge are Jolene Baum, Susan Beckman, Susan Bunting, Morgan Hartman, Judy Hearon, Lisa LaTurno, Sam Lyons, Kelli Maquet, Ann Pratt, and Karen Robertie. Current outpatient staff members are Haroon Ar-Rasheed, Deb Carter, Joe Estrada, and Judi Stogdell-Koehler. Lisa Morrison, coordinator of intake services, and Vickie Meister, intake assistant/finance counselor, have also contributed to the development of the program. Dr. Michael Dennis, the developer of the Global Appraisal of Individual Needs, has been instrumental in the development of the CHS approach to assessment and treatment placement and has worked hard with the clinical staff to integrate both the clinical and research aspects of the assessment process. We thank and acknowledge Russ Hagen and the CHS Board of Directors, for their consistent support of the adolescent programs and research efforts that help to improve them. The following staff members contributed outlines of the Family Night sessions: Anne Duback, Ken Fosnot, Tanesha McQuirter, Sarah Oberst, Jeff Ohmart, Richard A. Risberg, Melissa Simmons, and Mary Ann Skupnick. We are also grateful to the ATM research staff who, although not involved in writing the manual, provided support to the project in numerous ways during the implementation of the study and the work on the manual: Marissa Cope, Bryan Garner, Jenny Hammond, Lora Passetti, Melissa McDermeit, and Eli May. We thank our CSAT project officers, Randy Muck and Jutta Butler, for their support of this work. We think that providing funding to evaluate and document existing adolescent treatment programs was an innovative idea and the products from this work will be a lasting contribution to the field of adolescent substance abuse treatment. We would also like to thank Doreen Major Ryan of Northrop Grumman Information Technology Health

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The opinions expressed in this document are solely those of the authors and do not represent official positions of CSAT or any other governmental agency. At this writing, the evaluation of the Chestnut outpatient program is promising, and the results of this evaluation will be published in the future.

This manual can be found online at www.chestnut.org. Please contact Dr. Susan Harrington Godley at sgodley@chestnut.org or Richard A. Risberg at rrisberg@chestnut.org regarding any questions about the Chestnut approach.

I. Introduction

The Problem

The latest evidence from the National Household Survey on Drug Abuse (NHSDA) shows that the percentage of young people using drugs is increasing—from 9.7 percent in 2000 to 10.8 percent in 2001. There was also a significant increase in the estimated number of persons age 12 or older needing treatment for a drug problem (Epstein, 2002). Clearly, the need for effective substance abuse treatment strategies for adolescents is great. Until recently, few of the promising adolescent treatment models tested through clinical trials research (Azrin et al., 1994; Liddle & Dakof, 1995) had been evaluated in actual practice settings. While there are increasing attempts to transport interventions developed through efficacy research into applied settings (Dennis et al., 2002; Liddle et al., 2002), there still have been few rigorous evaluations of existing treatment models that have evolved in communities around the country. Thus, it is impossible to know how well these interventions work and how they might compare with interventions that have been developed through clinical trial research. There is also some question as to whether or not interventions developed from efficacy research will work with the same effectiveness with the heterogeneous group of adolescents commonly enrolled in community-based treatment programs and can be carried out by staff currently employed in these programs. The treatment field also currently lacks information on treatment effectiveness for gender differences, rural and rural-remote adolescents, minority adolescents, adolescents with co-morbid conditions, and developmentally specific effects. Any one or a combination of these issues can interact with treatment to either inhibit or enhance effectiveness.

Description of the Adolescent Treatment Models Study

Through the Adolescent Treatment Models (ATM) study, CSAT sought out several promising adolescent treatment models across the nation serving a variety of populations, age ranges, treatment modalities, and geographical locations. These programs were expected to have established linkages to school, criminal justice, child welfare, and other community institutions involved with youth. They also were expected to have the ability to assess and treat or obtain treatment for co-occurring psychiatric conditions. The overall assessment and evaluation of

these treatment models was facilitated by the use of a common measurement tool, the Global Appraisal of Individual Needs (GAIN; Dennis et al., 1996).

The Chestnut local evaluation included several components including: 1) a monthly management report that provided data on performance indicators related to screening and admission, agreement to participate in the follow-up study, discharge data, and follow-up data; 2) collection of data reflecting the amount and type of services provided to adolescents; 3) measures of therapeutic alliance after two sessions; 4) a qualitative study based on interviews with staff, parents, and adolescent participants; 5) an outcome study; and, 6) participation in a cost study funded by CSAT and carried out by McKing Consulting Corporation. The target population for Chestnut's ATM study was adolescent substance users appropriate for treatment based on ASAM criteria (PPC-2R; ASAM, 2001) for Level I (Outpatient) and Level II (Intensive Outpatient) treatment. The assessment was made with the GAIN, which was used both as a clinical assessment tool and the evaluation measure. Based on the GAIN assessment and a conference between the assessor and a supervisor, an adolescent was recommended for placement in a certain level of care. If this recommendation was for Level I or II outpatient treatment and the adolescent accepted the treatment recommendation, he or she was approached about study participation. The adolescents had to be able to understand and be willing to sign the informed consent, and have a significant other (typically a parent) who understood and was willing to sign a collateral consent form.

Ultimately, 151 adolescents were recruited for participation in the outcome study over 21 months and were interviewed at 3, 6, 9, and 12 months post-intake. Intake and follow-up data will be compared in a quasi-experimental design with outcomes from the Cannabis Youth Treatment Study in Madison County, Illinois. The population of the two studies is very similar with regard to demographics and clinical severity. Both studies used the GAIN measures at the same intervals post-intake. To validate self-reported data and facilitate comparison with the CYT outpatient protocols, we will also conduct urine and collateral assessments at 3 and 6 month time points.

Publications based on the qualitative, process, and outcome aspects of the study will be forthcoming. One study that has already been published grew out of the steering committee's review of screening and admission procedures and an attempt to streamline and improve the process (Garner et al., 2002). This study compared a cohort of 128 adolescents receiving the

standard admission procedures over a 12 month period with a subsequent cohort of 149 who received streamlined procedures that included same day assessments, same day recommendations, use of pre-set admission appointments, and admission tracking procedures. The new admission procedures were implemented in at least 50% of the cases. Adolescents who received them completed their assessments sooner, and time-to-event analysis demonstrated that this group was admitted to treatment sooner. More total adolescents were admitted to treatment under the streamlined admission procedure, but the percentage of adolescents who entered treatment was not significantly different between cohorts.

Purpose, Development, and Organization of This Manual

This manual was developed so that others would have a guidebook if they wished to replicate some or all of the Chestnut program approach. This was a challenging task. One of the authors had written a treatment manual before, but it concentrated on clinical procedures used during a finite number of sessions. Trying to describe an existing treatment program and all its components from screening to discharge was a much larger task. When we began the process to develop a treatment manual, a draft already existed. Chestnut has been a program long accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and licensed by the State of Illinois. Both JCAHO and licensing standards require that a description of the program exist and that certain requirements be met in terms of assessment, staff, and other aspects of service delivery. When we began to look at existing documentation, it became clear that the skill group sessions were well documented. There were other parts of the program, however, that appeared to be communicated primarily by word of mouth during on-the-job training. For example, there was less written about how a master treatment plan was developed or what occurred during an individual counseling session or when it was appropriate for an adolescent to receive individual counseling. This manual is an attempt to describe in more detail some of the nuances of the program that would typically be communicated as part of an outpatient staff member's training and to include copies of the various forms that are used in the program.

The manual has fifteen chapters and seven appendices. Chapter II provides an overview of the model. Chapter III provides additional details about how adolescents are recruited, assessed, and placed in treatment. Chapter IV provides an overview of treatment components.

Chapters V through IX elaborate on different components of the treatment program. Chapter X describes the program's approach to addressing common clinical problems seen in the program. The adolescent transfer and discharge process is described in Chapter XI. Chapters XII through XIV provide information on staff characteristics and requirements, clinical supervision, and staff training. Chapter XV describes other types of specifics related to implementing the program including facility needs, staff meetings, and quality improvement activities, and the final section provides the references used. The appendices include the following: A: Key Terms; B: Job Descriptions for Key Staff; C: Materials for Skills Groups; D: Outlines for Family Night Sessions; E: Clinical Forms; F: Youth Outpatient Services Handbook; and G: Additional Resources (including website information and training resources).

II. Overview of the Treatment Model

History of the Program

Chestnut Health Systems began in 1973 under the name of the McLean County Alcohol and Drug Assistance Unit, Inc., and later became known as Lighthouse. Lighthouse initially offered services primarily to adults. From the beginning into the early 1980s, a small number of adolescents and their families were also in the adult residential program. In 1985, Chestnut received funding from the Illinois Department of Mental Health, division of Alcoholism's Youth Initiative for Residential, Outpatient, and Early Intervention service in the schools. In 1990, case management and dual diagnosis services were added to the Bloomington services with additional funding from the federal Office of Treatment Improvement (which later became the Center for Substance Abuse Treatment). The Bloomington Outpatient program underwent major revisions in 1993 in response to a low census (averaging 12 to 16 adolescents) and the recognition that many youth in need of services were not being served. A new curriculum was designed for outpatient skills groups, and transportation was provided to and from treatment for adolescents. Prior to that year, the outpatient (OP) and intensive outpatient (IOP) programs primarily served adolescents who were receiving aftercare services post residential treatment. The advent of American Society of Addiction Medicine (ASAM) patient placement criteria in 1996 also spurred the development of outpatient counseling as a treatment option in its own right. Chestnut's adolescent substance abuse treatment program is now the largest adolescent provider in the state, with 4% of all public admissions (Dennis et al., 1999). In 2000 and 2001 the average daily census for the program was 46 adolescents.

Area Served

The treatment program is located in and serves McLean County (southwest of Chicago in Central Illinois), which is the largest geographical county in Illinois covering 1,184 square miles. With a 2000 population of 150,433, it includes a mix of more that 20 rural communities and the metro area of Bloomington (64,808) and Normal (45,386). The county's major employment sectors are service (25%), finance—particularly insurance—(18%), and government (17%). The twin cities are home to two major universities, Illinois State University and Illinois Wesleyan University. According to the 2000 census, the county population is approximately 6% African

American, 3% Asian, 3% Hispanic, and 88% Caucasian (not Hispanic). Of the residents age 25 and over, 33% have a high school degree (or its equivalent) and 52% have some post-high school education. The county is the third fastest growing in the state and has a healthy economic base as evidenced by an unemployment rate of 2.5% in 2000.

Facilities, Accreditation, and State Requirements

All levels of care, as well as medical and psychiatric services, are located in two facilities located on one campus. One facility includes both outpatient group rooms and three residential units that have a combined capacity of 48 beds: one for females, one for males, and one for males with extensive involvement in the criminal justice system. The second building includes additional outpatient staff offices, group rooms, a full sized gymnasium, and a classroom for the on-site school. Of youths (under age 19) admitted to Chestnut, 63% are seen in outpatient settings; statewide 84% of adolescent admissions are in outpatient settings (Dennis et al., 1999). All programs are accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and are required under state regulations to conduct a needs assessment, use diagnostic practices, use ASAM patient placement criteria to determine their level of care, and develop an individualized treatment plan. A diagnosis is assigned according to the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV; American Psychiatric Association, 1994) and a level of care is determined according to the Patient Placement Criteria for the Treatment of Substance Related Disorders (PPC-2R; ASAM, 2001).

Target Population Characteristics and Demonstrated Needs

Tables 1 and 2 provide data regarding the demographic and clinical characteristics of the program based on 151 adolescents who agreed to participate in the ATM study. The majority of the adolescents were male (74%), white (79%), attended school in the past 90 days (92%), and lived with a single parent (52%). Over half were either 15 or 16 years old, and most (76%) began experimenting with alcohol or drugs before age 15. Seventy-one percent reported using or needing treatment for marijuana, 26% for alcohol, 5% for hallucinogens, and 8% for other drugs. In the 90 days prior to their assessments, they reported an average of 26 days using alcohol, marijuana, or other drugs, 9 days when they were drunk or high for most of the day, and 11 days in jail or another place where they could not use drugs. Seventy percent reported that this was

their first substance abuse treatment episode, while 27% reported having one or two prior treatment episodes. They reported being arrested, charged with a crime, and booked an average of 2.5 times. Seventy-two percent reported current involvement with the criminal justice system.

Table 1. Characteristics of CHS Outpatient and Intensive Outpatient Adolescents at Intake (N=151)

Item	N	%
Gender		
Male	112	74
Female	39	26
Age		
11-12	0	0
13-14	18	12
15-16	85	56
17-18	47	31
19 and older	1	1
Ethnicity		
American Indian/Alaska Native	2	1
Asian or Pacific Islander	1	1
Black	15	11
White	120	79
Hispanic (Puerto Rican, Mexican, Cuban, other)	4	3
Mixed/some other group	9	7
Current Living Situation		
A house or apartment (yours or parents)	138	91
A foster home or public housing	4	3
A friend's or relative's house or apartment	6	4
A nursing home, hospital, inpatient, or residential	0	0
Jail, detention center, or other correctional institution	3	2
Current Living Situation (continued)		
Temporary or emergency shelter	0	0
Vacant buildings	0	0
Any other housing situation	0	0
Present Work or School Situation		
Working full time	7	5
Working part time	15	10
Unemployed or laid off	14	9
Have a job, but not working because of treatment, illness, seasonal	1	1
In school or training only (even if not in session now)	77	52
In school or training at all in past 90 days	139	92
In jail or prison	3	2
Some other work situation	2	1
Substance Dependence (meeting criteria)	79	52

Table 1 (continued).

Item	N	%
Substance Needed Treatment for[1]		
Any kind of alcohol	39	26
Marijuana, hashish, etc.	107	71
Crack, free base cocaine, other cocaine	2	1
Amphetamine/methamphetamine	3	2
Inhalants	2	1
Heroin	0	0
"Acid" or other hallucinogens	7	5
Some other drug	6	4
Age When First Got Drunk or Used Any Drugs		
Younger than 15	115	76
15-18	36	24
Older than 18	0	0
Last Grade or Year Completed in School		
<6	0	0
6-8	39	26
9-10	90	60
11-12	22	15
>12	0	0
Legal Custody		
Parents together	45	30
Parents separated	9	6
Single parent	78	52
Other family	2	1
County/State	2	1
Juvenile or correctional facility	0	0
18 or older	11	7
Other	4	2
Times in Life Arrested, Charged with a Crime, and Booked		
0 times	32	21
1-2 times	71	47
3+ times	48	32
Times in Life Admitted to Drug Treatment or Counseling		
0 times	106	70
1-2 times	39	27
3+ times	6	4

[1]Calculated from adolescent self-report of need for treatment unless adolescent reports no need for treatment, then calculated from counselor determination. Total will be greater than 100%.

Table 2. Means and Standard Deviations for Select Characteristics of CHS Outpatient and Intensive Outpatient Adolescents at Intake (N=151)

Item	Mean	S.D.
Times in Life Arrested, Charged with a Crime, and Booked	2.5	3.3
Substance Use in the Past 90 Days		
Days used alcohol, marijuana, or other drugs	25.5	26.0
Days drunk or high for most of the day	9.2	16.2
Days in a jail (or other place) where you could not use drugs	10.7	21.5
Times in Life Admitted to Drug Treatment or Counseling	0.5	0.89

Substance Abuse Prevalence

A review of McLean County data from the 2000 Illinois Youth Survey of high school youth shows that alcohol and marijuana were the drugs of choice among adolescents in grades 8, 10, and 12 (M. McDermeit, personal communication, April 25, 2001). Forty-two percent reported alcohol use in the past month and 26% reported binge drinking (5 or more drinks in a row) in the past two weeks. Thirty-two percent reported using marijuana in their lifetime, 25% said they used it in the past year, and 16% said they used it in the past month. The percentages of students reporting use of inhalants, hallucinogens, and crack/cocaine in the past year were 4%, 3%, and 3% respectively.

Among the outpatient treatment population (N=151), the largest percentage had a diagnosis of cannabis dependence (54%), followed by cannabis abuse (30%). Forty-nine percent had diagnoses of alcohol abuse or dependence and only 3% had diagnoses of cocaine abuse or dependence. As expected, an examination of diagnostic data from our residential population revealed greater severity. Almost 20% of these adolescents had cocaine abuse or dependence diagnoses, 85% had alcohol abuse or dependence diagnoses (most with dependence), 90% were diagnosed with marijuana dependence and 7% with marijuana abuse.

Conceptual and Theoretical Framework

The program is based on a blended therapeutic approach. It draws upon four theories of behavioral and emotional change (Rogerian, behavioral, cognitive, and reality therapy) and includes 12-step concepts and approaches. Rogerian concepts include unconditional positive regard, acceptance, building rapport, and empowering the adolescent (Rogers, 1951, 1959). Behavioral approaches include focusing on skills building/learning, behavior modification

techniques, and habit control (Chiauzzi, 1991; Hester & Miller, 1989; Kazdin, 2000). Cognitive theory emphasizes evaluating perceptions and thoughts, and changing thinking patterns by reframing and cognitive restructuring (Ellis et al., 1988; Walen et al., 1992; Yankura & Dryden, 1990). Reality therapy focuses on choices and their consequences, emphasizing that experiencing the consequences of their actions will help teach adolescents about responsibilities, and that their life problems are directly related to the choices they make (Glasser, 1976, 1992). There is also a strong emphasis on the early detection of substance use, the identification of Attention Deficit Hyperactivity Disorder (ADHD) and conduct disorder (Adams & Wallace, 1994; Risberg et al., 1995), and family involvement (Risberg & Funk, 2000). More recently, staff have been influenced by the principles and techniques found in motivational interviewing (Miller & Rollnick, 1991). These principles and the need to consider development issues associated with adolescence shape and guide all treatment interventions for adolescents and their families.

Overview of the Treatment Process

The outpatient treatment model described in this manual consists of several different components that meet the needs of different types of adolescents that can range from one to 25 or more service hours per week depending on individual needs. The least intensive level of care is the Student Assistance Program (SAP) services in the school. The Outpatient Program (OP) provides from one to eight hours of treatment groups per week. The Intensive Outpatient Program (IOP) provides from nine to 12 hours of treatment groups per week, and the Day Treatment Program typically provides 20 or more hours of services per week. Adolescents who do not meet criteria for treatment, but are in need of continued monitoring, are sometimes referred to their school counselor, SAP specialist, probation/parole officer, or other professionals working with the youth and their family.

The process begins when an adolescent or another referral source first contacts the agency for help. Typically, the initial contact is by telephone. During the call enough information is gathered to determine whether further exploration of a substance abuse problem is warranted, whether the adolescent is a member of one of the state's priority populations, and the level of urgency. Adolescents in crisis are provided immediate assistance. Non-emergency or routine callers are scheduled for an assessment within 10 business days. Case managers also

provide screening services out in the field; for example, at a local detention center or at a state correctional facility.

A comprehensive biopsychosocial evaluation provides information to determine whether a substance abuse problem exists. If this information indicates the need for treatment, then a DSM-IV diagnosis and a level of care recommendation will be made. The evaluation will also help identify other problem areas that will need to be addressed in treatment. An assessment includes the administration of the Global Appraisal of Individual Needs-Initial (GAIN-I; Dennis et al., 1996) and if necessary, collaborative reports from schools, probation, and other treatment providers. The evaluation information is reviewed as soon as possible after the assessment with a clinical supervisor to determine the appropriate level of placement, and the adolescent is informed of the recommendation. If the adolescent and guardian(s) are willing to comply with the recommendation and pursue treatment, the adolescent is assigned to a primary counselor and an admission time scheduled. When additional collaborative information is required, a final staffing is completed within seven to 14 days. In the latter case, the counselor attempts to contact the family within 24 hours of the staffing and schedule an admission time within five business days.

Treatment recommendations are determined using ASAM criteria (PPC-2R; ASAM, 2001). Many factors enter into the projected length of stay and the recommended level of care. These factors include: previous treatment involvement, time spent incarcerated, the adolescent's age, psychiatric issues, level of social skills, level of denial/defensiveness, level of motivation and change, and his or her recovery environment (e.g., gang involvement, substance use in the home, the availability of Alcoholics Anonymous [AA]/Narcotics Anonymous [NA] meetings). An adolescent's actual time in treatment is determined by his or her progress on achieving the goals identified in his or her treatment plan.

Once the adolescent is admitted to treatment, the counselor works with the adolescent to develop a Master Treatment Plan (MTP) based on findings from the assessment process. The MTP includes: (a) an approval sheet which is signed by the adolescent, counselor, and supervisor; (b) a list of the adolescent's strengths as perceived by the adolescent, family, and staff; (c) a list of different skill groups and individual sessions the adolescent is required to attend, the expected frequency of attendance, a list of other family members that are expected to be involved in the adolescent's treatment, and a description of how issues (e.g., medical) that

might impact participation in treatment will be addressed, and; (d) specific treatment objectives and interventions by each ASAM dimension that need to be addressed, the responsible staff, and time frame (i.e., the estimated date of completion).

The primary mode of treatment in the outpatient program is through skill building groups and counseling groups. To accommodate different adolescent school and work schedules, OP treatment groups are offered from 4 p.m. to 7 p.m., Monday through Thursday, and when appropriate, from 10 a.m. to 12 p.m. on Tuesdays and Thursdays. Most adolescents attend the evening groups. Each skills group is composed of 12 or more modules that are repeated cyclically and are offered during the course of a week. Group sessions last 45 minutes and there are 15 to 20 different group sessions every Monday through Thursday. On Mondays and Tuesdays, two groups are sometimes conducted simultaneously, depending on the number of clients attending that evening.

Skill building group topics include relapse prevention, life skills, self-esteem, family issues, recovery lifestyle, and recreation/leisure. Virtually all adolescents attend at least one counseling group each week. In addition, adolescents are strongly encouraged to attend several AA/NA self-help meetings in their community. Upon completion of treatment, most adolescents are encouraged to continue to use this avenue of support. Periodically, adolescents are transported to an AA/NA meeting as part of their treatment.

Individual counseling sessions are also incorporated into the adolescent's treatment plan. These sessions frequently address specific goals found in the MTP. Counselors often use individual sessions to address issues related to age and gender (gender-specific counseling groups are also provided). In addition, nursing staff are available to spend individual time with adolescents. An HIV/AIDS/TB educator/counselor is available and regularly presents information in a skills group. All adolescents are given the opportunity to meet with this counselor on an individual basis. If the adolescent desires to do so, they can be tested for HIV free of charge.

Counselors strongly encourage family participation in the adolescent's treatment to help the adolescent develop a recovery lifestyle. The primary opportunity for this participation is the Family Night Program. Family Night is a weekly, two-hour session consisting of an hour of didactic lecture and an hour of group family counseling. Family Night is open to any person who is interested in providing positive support to an adolescent, including teachers, case

workers, and friends. Adolescents participate only in the second hour of Family Night. Family involvement is considered an integral component of each adolescent's treatment program. Three to six individual family sessions are offered throughout the course of treatment. Unfortunately, some adolescents' families refuse to participate in either the Family Night Program or family counseling sessions. Some adolescents are wards of the Department of Children and Family Services (DCFS) and do not have any family involvement. However, counselors work closely with DCFS and attend staffings with DCFS case workers. Counselors strive to facilitate communication and a unified approach among all agencies involved in an adolescent's treatment. This approach includes work with probation or parole officers, school officials and counselors, psychiatrists, and any other agency providing services to the adolescent. Counselors maintain regular telephone contact with the professionals involved in each adolescent's life. These close contacts often result in the ability to address emerging problems before they become overwhelming. Probation officers and parole officers have consistently worked with counselors and have been supportive of CHS treatment goals.

The adolescent's primary counselor regularly assesses how adolescents are progressing in completing their MTP goals. As adolescents near the completion of their MTP goals, the entire staff discusses their progress and readiness for discharge. Their primary counselor discusses recommendations that will support the adolescent's self-directed recovery program when they leave treatment. The counselor may also recommend continued family counseling, psychiatric follow-up, using a sponsor, following through with legal obligations, addressing any medical issues, maintaining contact with school counselors, avoiding old drug-using friends, and participating in non-using leisure activities. Nearly all adolescents are encouraged to attend AA/NA meetings, and women are encouraged to also attend all-women AA/NA meetings.

When adolescents are discharged, family members are invited to participate in a final family counseling session. The family and adolescent are asked to sign discharge papers that outline the discharge plan. During this time the adolescent can review their relapse prevention plan with the family and the counselor can emphasize the positive changes that occurred while the adolescent was in treatment. Upon completing this final session, the adolescent and his or her family are encouraged to re-contact the primary counselor if needed.

Communication among outpatient staff members about adolescent issues is ongoing and occurs on a daily basis. All staff members are encouraged to consult with each other to seek

information and guidance on specific adolescent issues. To foster communication among staff about adolescents, two staff meetings totaling three hours are held each week. Staff may discuss interventions for specific adolescents, the progress of an individual adolescent toward completing his or her treatment plan goals, changes in goals, and in general, how best to intervene with adolescents. Gender, cultural, and age issues are also addressed at staff meetings. Appropriate skills groups are determined for each adolescent. Each adolescent's developmental level, level of motivation, prior treatment history, and personal needs are factored into the development of their group schedule. These considerations also determine individual and family counseling needs.

The goal of CHS adolescent outpatient services is to provide comprehensive, cost effective, and positive outcome treatment services. The emphasis is placed on developing individualized treatment plans; treating the family as well as the adolescent; developing caring, therapeutic relationships founded on honesty and openness; and providing a safe, therapeutic milieu where the adolescents and their families can feel comfortable addressing the difficult issues associated with substance abuse.

III. Recruitment, Assessment, and Treatment Placement

Recruitment Activities

Recruitment for outpatient services is accomplished in a number of ways including advertising, linkages with agencies and schools, and case management outreach. Free assessments are provided for youth who live in McLean County—the primary catchment area for outpatient adolescents. The program is advertised through radio announcements and special events. Agency staff members have developed linkage agreements with over 80 agencies including hospitals, social service agencies, court services, the Department of Corrections, schools, and treatment facilities. These agreements specify expectations between CHS and the respective agency. Staff also network with professionals from other agencies by participating on interagency committees like the Local Area Network, a group which discusses and makes plans to address the needs of multi-problem youth and their families.

Case managers play an important role in recruitment. They regularly visit (every month or two) with referral sources to reinforce CHS's commitment to working closely with referral sources. The visits help keep minor problems from becoming significant through frequent contact and discussion. Case managers also maintain regular contact with the adolescents who are referred for an evaluation. Adolescents will frequently avoid scheduling the evaluation even though they are court-ordered to do so. Case managers enlist both family members and probation to apply pressure on the adolescent to follow through with the evaluation. If a treatment recommendation is made, case managers follow up with prospective adolescents to facilitate scheduling an admission appointment.

Chestnut's largest referral source is the criminal justice system. Informational meetings with probation officers, parole officers, and judges are focused on making the referral process as easy as possible. Under CSAT's Strengthening Communities for Youth initiative, CHS has placed a case manager on-site at court services to conduct screening and evaluations. Case managers also conduct evaluations with adolescents who are incarcerated either in detention, the county jail, or the Department of Corrections. Since clinical experience suggests that relapse frequently occurs when an adolescent is released from jail, both family and probation are contacted and reminded that their son/daughter will be evaluated at the earliest convenience after the adolescent is released.

The adolescent program has student assistance program (SAP) specialists in 22 schools in the county. These specialists are able to educate school personnel about issues related to substance use, addiction, and CHS services. They are also in positions to screen youth who may be suspected of having substance use problems and refer them for an in-house assessment or other services. They work with OP staff to make appropriate referrals to treatment and to provide support to an adolescent in the school environment.

Outside of the schools, most of the referrals to the program are by telephone. During referral telephone calls, enough information is gathered to determine whether substance abuse may be a problem and if further exploration is warranted. If adolescents are in crisis, they are provided immediate assistance. Otherwise the adolescent and their parent or guardian are scheduled for an assessment within ten business days. On-site at schools, student assistance specialists will typically complete a GAIN-Quick (GAIN-Q), which will determine whether a more in-depth assessment is needed. At the court services office or the detention center, either a GAIN-Q or the full GAIN-I is completed depending on the information provided. For example, most adolescents at court services are given a urine test prior to seeing the case manager for an evaluation. If the urine test results are positive, they will usually be administered the GAIN-I. If they are negative, then they will be given a GAIN-Q.

Assessment and Placement Process

Once an adolescent is determined to need a comprehensive assessment, one will be provided at no cost to the adolescent or the family. It includes a biopsychosocial assessment based on the GAIN-I (Dennis et al., 1996), a medical assessment (full physicals where indicated), interviews with collaterals, and a urine test if indicated. (Typically, the state substance abuse treatment authority reimburses the costs of assessments.) The GAIN-I is completed via an interview by a case manager or a substance abuse counselor. This instrument includes over 1500 questions and 100 scales (see work by Dennis, Dawud-Noursi, Muck, and McDermeit [2003] or www.chestnut.org) and takes an average of 90 minutes. Urine tests are conducted in the event that an adolescent denies any substance use.

When accepting referrals from certain substance abuse treatment providers who are designated by CHS as "Level I" referring agencies, the assessment process works differently. This type of linkage agreement helps CHS to provide treatment services efficiently, to transition

adolescents quickly between levels of care, and to encourage working relationships among providers. In these cases, CHS accepts the referring agency's professional opinion that the adolescent meets ASAM criteria for the level of care recommended. CHS staff members conduct only minimal initial screening to obtain some basic information (i.e., diagnosis, ASAM criteria met, the reason for the referral). Most often, these types of referrals will be for residential treatment, although occasionally a Level I referral agency will request that an adolescent be placed in the OP program for aftercare services. In this situation, an admission date is often scheduled within 24 hours of the initial phone call. The adolescent and family complete both assessment and admission paperwork during their first contact with CHS.

Staffing to Determine the Treatment Recommendation

After the case manager has completed the GAIN-I with the adolescent and obtained the Collateral Assessment Form from the guardian, the case is staffed. If an adolescent has denied any substance use or any recent use, a urine screen may be used to verify this self-report so that a recommendation for no treatment or outpatient treatment is not made on faulty information. All assessments are staffed with a clinical supervisor or another senior clinical staff member to determine the appropriate treatment recommendation. Potential recommendations include: (a) no treatment at this time, (b) referral to a student assistance program specialist in the adolescent's school, (c) referral outside of CHS for other types of services such as family counseling or mental health counseling, (d) placement in OP or IOP, (e) placement in day treatment, or (f) placement in residential treatment. Treatment recommendations are determined based on ASAM criteria (PPC-2R; ASAM, 2001) per Illinois state guidelines. While ASAM criteria provide general guidelines, each adolescent's particular situation is taken into account. Many factors enter into the recommendation for level of care and an adolescent's projected length of stay. Some of these factors include previous treatment involvement, time spent incarcerated, the age of the adolescent, psychiatric issues, level of social skills, level of denial/resistance, developmental issues, and the nature of their recovery environment (e.g., gang involvement, substance use in the home, and the availability of AA/NA meetings). If the staffing recommendation is outpatient treatment, the goal is for the adolescent to leave the assessment appointment with a scheduled time for an admission session with his or her primary counselor.

Informing Adolescent and Family of the Recommendations

When adequate information is available at the staffing to make a treatment recommendation, the case manager then meets with the adolescent and a guardian. The rationale for the treatment recommendation is explained. The case manager answers any questions and explains the admission process. If the adolescent is willing to follow through with the treatment recommendation, an admission date and time is scheduled for the adolescent and guardian. Some families request time to think about the recommendation prior to scheduling an admission. In this circumstance, the case manager lets the family know that if they do not hear from them in several days, they will contact them to see if they are going to follow though with the recommendation.

Assignment to a Primary Counselor

A weekly schedule of all primary counselors' admission times is located in a scheduling book. The outpatient coordinator determines which counselor should receive the first adolescent scheduled that week, the second adolescent scheduled that week, and so on. When an admission time is scheduled, the case manager leaves voice mails with the counselor and the outpatient coordinator. The appointment is also written in the admission schedule book. If the counselor who is to receive the next adolescent does not have an admission time that is acceptable to the family, the case manager lets the family know that a counselor will contact them within a day to schedule an admission time. Individual characteristics or situations may suggest that a specific adolescent would be more responsive to a particular counselor. For example, a male counselor may be indicated for a male adolescent who has had relatively few male role models in his life. Or a severely conduct disordered adolescent might be better treated by a counselor who has a more cognitive-behavioral orientation, who tends to be more structured and concrete with expectations and goals. In those instances, the adolescents would then be assigned to the appropriate counselor, if at all possible.

Special Situations

Step-Down Adolescents

Step-down adolescents have recently successfully completed residential treatment and are transferred to the OP program. Other terms used to describe this type of service are "aftercare"

or "continuing care." If the adolescent is transferred from the CHS residential program, minimal assessment is needed. The adolescent's residential counselor has 24 hours after transfer to provide a transfer/discharge report to the respective OP counselor. The report identifies goals that the adolescent needs to continue working on while in OP/aftercare services. The transfer process does not require assessment by a case manager.

If the adolescent completes residential treatment at another facility, the prospective adolescent completes an assessment with a CHS case manager in order to confirm the other facility's recommendation. The adolescent is then assigned to a CHS OP counselor. There have been very few instances when there was a waiting list for OP treatment. After the referred OP or IOP adolescent completes an assessment, the case manager or OP counselor then sets up the admission appointment. Aftercare or step-down adolescents generally attend groups on Wednesdays for two to four months. These groups are specifically designed to help aftercare adolescents maintain a recovery-oriented attitude and support activities that sustain recovery such as regularly attending AA/NA meetings, avoiding their old drug-using friends, and following through with any medical or psychiatric recommendations.

Former Treatment Participants

It is common for former participants to re-enter treatment following both successful and unsuccessful previous treatment experiences. The evaluation and assessment process depends on how long the adolescent has had no contact with CHS. If it has been six months or longer since the last contact, the adolescent completes a case management assessment and a treatment recommendation is made. They enter treatment in the same way as new adolescents. For adolescents who have had contact with CHS in the last six months, an assessment update is completed. If the adolescent had been an OP or IOP adolescent, he or she is typically assigned to their previous counselor. In this case, the counselor often completes the assessment update rather than a case manager. This occurs when initial information suggests that the adolescent is appropriate for either OP or IOP.

All adolescents who are unsuccessfully discharged from CHS leave with a treatment recommendation. If the adolescent is incarcerated, he or she will be court-ordered to follow CHS' treatment recommendation when they are released from jail or prison. Former adolescents who have successfully completed OP may again be referred for OP or IOP. There are a few

unique factors related to assessment and treatment of this type of adolescent. The adolescent is usually assigned to his or her previous counselor, assuming a positive relationship had been developed. Since the adolescent already has an understanding of the rules and procedures of the program, and has often developed trusting relationships with staff members, expectations are generally higher from the beginning of treatment. In a sense, the counselor can begin treatment where he or she left off when the adolescent was previously discharged. This approach is moderated by the adolescent's level of motivation to change. However, most adolescents who return after successfully completing treatment are not in the precontemplation stage. That is, life consequences have again proven to the adolescent that they have problems with substance use.

Admission Appointment

Both the adolescent and guardian are expected to attend the admission appointment. The receptionist has the adolescent complete an adolescent demographic form (a state funding requirement). Then the adolescent and guardian meet with a financial counselor to discuss methods of payment (e.g., Public Aid, insurance, or grants made available through the state Office of Alcohol and Substance Abuse). Because CHS receives state funding, services are not denied to anyone based on their inability to pay. If a call to an insurance company is required, the Adolescent Intake Assistant gives the counselor information to facilitate the call.

The counselor then meets with the adolescent and guardian. While there is admission paperwork to complete, the admission process is considered a family session and emphasis is placed on building rapport. Both the adolescent and guardian are asked about problem areas and to help develop treatment goals. The counselor explains the different interventions that are required parts of the OP/IOP program including skills and counseling groups, individual and family therapy, AA/NA or Cocaine Anonymous (CA), and the Family Night program. Behavioral expectations of adolescents are also discussed and the adolescent signs a behavioral contract. The counselor determines who will be the primary collaterals that will be contacted throughout the adolescent's treatment experience (e.g., family members, probation or parole, school, family doctor, family psychiatrist, etc.). CHS counselors place the responsibility for change with the adolescent and guardian, while working to cultivate a sense of collaboration. They emphasize that treatment can provide education, skills training, and support, but that its effectiveness is dependent upon the adolescent's level of honesty, openness, and willingness.

Most importantly, the counselor works to impart a sense of hope that positive change can occur, and that CHS's goal is to help and support the adolescent and family through this difficult, yet manageable time. The adolescent and family are provided a copy of "Youth Outpatient Services Handbook" (see Appendix F). The handbook explains CHS's treatment philosophy, the importance and limits of confidentiality, expectations of the adolescent and his or her family, counseling group rules, and the variety of services offered by the outpatient program.

Screening and Admission Statistics

A review of screening and admission statistics for an eleven-month period (in 1999-2000) revealed that approximately one-fourth of the adolescents screened by telephone for OP or IOP services were admitted within four weeks of their assessment. Of the 265 adolescents who were screened by telephone, 86% completed the assessment process. Of these, 66% were recommended for outpatient treatment. Fifty-one percent of the adolescents recommended for one of the outpatient modalities were admitted within 28 days of their assessment. The remainder either did not set up an admission appointment at CHS or failed to attend repeated appointments. During this period, most referrals were made by a juvenile detention center (23%) or family members (22%). Other referral sources included probation and parole (17%), schools (12%), self (3%), other substance abuse treatment providers (3%), judges (3%), the state's child welfare agency (2%), and other sources (6%). Additionally, 6% of the admissions were adolescents who "stepped-down" into outpatient from residential treatment.

IV. Overview of Treatment Components

Individual Work with the Adolescents

The primary modes of treatment in the OP/IOP program are skills and counseling groups. However, counselors are also expected to provide individual sessions to each adolescent. Individual sessions are always conducted to develop the MTP and to review progress toward accomplishing MTP goals. They may be used to increase an adolescent's motivation to complete treatment goals and to address special needs, especially since the development of a strong therapeutic alliance may best occur in an individual counseling situation. Examples of special needs that would be addressed in individual sessions are developmental and gender-specific issues. For example, if an adolescent was young chronologically and/or developmentally and was expected to have difficulty with group dynamics in a treatment group of older teenagers, the treatment team could decide that individual treatment was most appropriate. Even though the program offers gender-specific counseling groups, a counselor would address sensitive issues, such as sexual preference or sexual abuse, in individual sessions.

Adolescent Skills Groups

Skills groups covering fourteen different topics are offered during the week. Assignment to the number and type of groups is based on the assessment and the adolescent's personalized MTP goals and objectives. To accommodate different adolescent school and work schedules, OP treatment groups are offered from 4 p.m. to 7 p.m., Monday through Thursday, and if needed, from 10 a.m. to 12 p.m. on Tuesdays and Thursdays. Most adolescents attend the evening groups. Each type of group is composed of 12 or more modules that are repeated cyclically. Topics addressed in skills groups are varied and include anger management, stress management, relapse prevention, decision-making, drug education, and relationships. For descriptions of the skill group areas see Chapter VI, and see Appendix C for materials used in the skills groups.

Adolescent Counseling Groups

Counseling groups are offered four nights a week. These groups provide the opportunity for adolescents to discuss personal issues. Adolescents are encouraged to focus on how they can

effectively deal with problems and issues in their lives. They are asked to discuss what has been helpful to them in the past. Peers are asked to give feedback and relate the issues to their personal experiences. Gender specific groups provide the most comfortable setting for discussion of some of these topics. An art therapy group is offered once per week.

Family Night

One way that CHS attempts to involve families in the treatment process is to provide one night per week of services specifically designed for the families of adolescents. Family Night is designed to address the issues common to families with an adolescent substance abuser. The Family Night program offers both education and support, and the program is presented every Tuesday night from 6:00 p.m. to 8:15 p.m.

The first hour of Family Night is held while adolescents are in skills groups. During this time, counselors present information on a variety of topics to parents and other members in attendance. These topics include family roles, drug education, relapse signs and prevention, denial, coping styles, enabling/detachment/parenting styles, goals and objectives, adolescent development, emotions, and HIV/AIDS education. Questions and comments are encouraged from the group participants.

After a 15-minute break, the adolescents join their families for the second hour of Family Night. While both residential and outpatient families attend the first hour together, they are split for the second hour of group family counseling. Typically two outpatient counselors lead each counseling group. The topics addressed depend on the needs of the families present.

Family Counseling Sessions

Besides the multi-family counseling offered during Family Night, primary counselors are also encouraged to offer family counseling sessions for individual families. By the time their child enters treatment, parents are often quite frustrated, angry, afraid, and ill-prepared to help their son or daughter develop a drug-free lifestyle. Family counseling can assist with improving communication skills and problematic interpersonal dynamics, focusing on positive changes, and learning how to be supportive and respectful of each other. Since parents or guardians are required to be present when the adolescent is admitted into treatment, this session is approached as a family session and it provides an opportunity for counselors to schedule a second family

session. Some adolescents may have only one or two family sessions, others may meet on a weekly or bi-weekly basis with the counselor, and unfortunately, others may be willing to attend only the admission session.

Family counseling sessions typically last from 45 minutes to an hour. A common task during these sessions is to review the MTP goals and discuss any progress that has occurred. Virtually all adolescents have MTP goals addressing family issues such as improving communication, behavioral and attitudinal issues, and/or job duties around the house. At times parents do not recognize positive changes their son or daughter is making in his or her life. The counselor can help the family be more sensitive to the adolescent's efforts at changing his or her behaviors. Prior to treatment, parents often dealt with the negative behaviors of the adolescent on a daily basis. Families are encouraged to use additional community supports including school counselors, teachers, coaches, religious leaders, probation officers, family, relatives, doctors, psychiatrists, and AA/NA/CA. When appropriate, referrals are made to community-based programs designed to meet specific needs such as pregnancy, housing problems, financial problems, recreational needs, and medical needs.

Treatment Goals and Change Mechanisms

Developing a strong therapeutic relationship between the adolescent and counselor is the basis for promoting change. The primary goals for adolescents are abstaining from substance use, setting and achieving personal treatment goals, and developing a supportive recovery environment that includes family, peer, and collateral support for sobriety.

CHS counselors incorporate the techniques of motivational interviewing (Center for Substance Abuse Treatment, 1999; Miller & Rollnick, 1991), solution-focused brief therapy (Budman, 1994), and the CHS theoretical foundations into the program's various change mechanisms. For example, the Rogerian principles of empathy, unconditional positive regard, and a collaborative partnership (versus expert/patient relationship) are strongly endorsed as part of the basic philosophy of helping others. The use of motivation enhancing procedures (Center for Substance Abuse Treatment, 1999) can help move the adolescent through the change process. This approach suggests utilizing different techniques depending on where adolescents are in their recovery process and their level of ambivalence or resistance to making changes. The following concepts guide the counselor's interventions.

- The counselor/adolescent relationship is a collaborative partnership. Treatment goals are negotiated between the counselor and the adolescent.
- The counselor is empathic, respectful, supportive, non-judgmental, optimistic, and accepting toward the adolescent. Self-efficacy (the belief that one can change) is nurtured and encouraged.
- Gentle persuasion and mild confrontation are used with the understanding that change is up to the adolescent. The counselor helps the adolescent develop discrepancies between their goals or values and current behaviors.
- The counselor is responsible for motivating the adolescent.

This therapeutic approach can be used in individual, group, and family counseling settings. CHS counselors try to incorporate these principles in all interactions with adolescents, family members, and collaterals.

Change mechanisms that are important components of the CHS program include promoting the therapeutic/collaborative relationship, developing the MTP, skills groups training and education, family education and involvement, non-family collateral education and involvement, urine screens, developing a structured and supportive environment, and staff cohesiveness. Each of these change mechanisms is described in more detail below.

The Therapeutic/Collaborative Relationship

The therapeutic relationship is a key variable in fostering positive movement/change in the adolescent. Acknowledging and accepting the adolescent's level of commitment to recovery can help promote a closer, empathic relationship. Normalizing ambivalence and recognizing the positive aspects of substance use tends to promote feelings of understanding and acceptance. Confrontation cannot be avoided at times, but it rarely needs to be demanding or negative. It is defined as directly addressing a negative behavior, emotion, or attitude, and helping the adolescent (or family) decide how to change and/or avoid repeating a problem behavior. It includes a discussion of the choices that the adolescent may make. The goal of mild confrontation is to enhance the adolescent's openness to the possibility that change on the adolescent's part might make his or her life easier, happier, more free, or less chaotic, and to avoid eliciting a defensive response.

Empowering the adolescent by placing the responsibility for change with the adolescent addresses both the adolescent's tendency to blame others and decreases resistance and defensiveness. It is typical for adolescents to be rebellious, so counselors work to avoid entering into a power struggle with adolescents that would place distance between them. Counselors work to help the adolescent focus on making changes rather than setting the stage for the adolescent to focus on resisting "the system." Blaming an adolescent's lack of change on denial and resistance is counter-productive to developing a trusting, empathic relationship.

Helping the Adolescent Set Individual Treatment Goals

The Master Treatment Plan (MTP) document identifies the relationship between treatment and the adolescent's emotional and behavioral life. It describes the impact of old behaviors and also the new behaviors that can reduce or eliminate difficulties. In addition to identifying the specific treatment goals, the MTP also lists the adolescent's strengths and the collaterals that need to be involved in the adolescent's treatment process.

Treatment goals are defined under the six ASAM dimensions for general problem areas (for a list of dimensions, see Appendix A: Key Terms). Specific goals/objectives are noted under the respective ASAM dimension. Each objective is behaviorally defined, states which staff will work with the adolescent on the respective goal, and the date the objective is expected to be completed. This approach follows JCAHO requirements and state regulations.

The adolescent and family are involved as much as possible in developing the MTP objectives. We believe that collaboration results in more compliance and less resistance. Working with the adolescent rather than dictating goals demonstrates respect and acceptance for the adolescent and also promotes a sense of responsibility for his or her behavior. This approach also acknowledges that adolescents may be at different stages of recovery. An adolescent may not see the value in some goals set by parents or probation (e.g., doing chores at home, going to school, avoiding certain friends, leaving clean urine screens). The counselor helps the adolescent see how working on these goals is in his or her best interest. A counselor might relate working on an objectionable goal (e.g., following house rules or obeying curfew) to the adolescent's goal of "getting my parents off my back" or "getting off probation."

Skills and Counseling Groups

From 15 to 20 skills and counseling groups are provided each week. CHS believes education is a change mechanism, and educating adolescents in a group format has several advantages. It is more efficient than individual sessions due to staff and time limitations. The group format allows for the adolescents to teach one another, to practice interacting and behaving appropriately in a school-type setting, and to hear personal examples from peers related to the respective group topic. Real-life examples from peers facilitate the learning process. Adolescents usually attend from three to 12 groups per week so that a significant amount of information is covered each week. How many and which groups an adolescent attends is based on individual needs identified in the MTP. (See sample MTP and group schedule at the end of the chapter.)

Nearly every adolescent who is scheduled to attend groups attends at least one counseling group. During these groups, adolescents are encouraged to talk about the problems they face, the goals they are working on, and any progress they have made. Periodically, counselors talk about confidentiality, group rules, and how group counseling can help the adolescents. Change can occur through insight. Change also occurs when an adolescent recognizes that other adolescents understand their situation and want to help them. Acceptance and empathy foster change, whether from a counselor or another adolescent. The counselor/group leader can "use" the adolescents who are in recovery. Their recovery-based feedback can have a powerful effect on adolescents who do not see the value of making changes in their lives. This is an opportunity to use peer pressure in a positive manner.

Working with adolescents in a group setting provides counselors with unending opportunities to address personal adolescent issues. Relationship issues, lack of assertiveness skills, anger and stress management problems, resistance to stop using substances, and difficulty expressing feelings are some of the issues that regularly surface in skills and counseling groups. The counselor's job is to make the situation non-threatening and help the adolescents explore alternatives. CHS counselors believe that change can occur, or begin to occur, simply by listening, and counselors and adolescent peers are involved in the listening process.

Family Involvement

Denial, resistance, lack of trust, and substance use are often family issues that the counselor must address in order to help the adolescent develop a supportive home environment. The same techniques used in individual counseling—collaboration, empathy, gentle persuasion, optimism, etc.—are effective in family counseling sessions. When adolescents or family members realize that the counselor understands their situation and is willing to work with them in a partnership, this increases the family's willingness to look at how they might be supportive of the adolescent.

Not only are family members taught and encouraged to support change in the adolescent, but they are also encouraged to make changes for their mental health. Counselors often recommend that family members attend Alanon or Families Anonymous. These self-help groups focus on detachment and avoiding enabling behavior. Parents have reported that self-help groups provide hope and direction regarding parenting and how to feel more in control of their lives.

The adolescent's home and family are clearly important aspects of their recovery program. Families are strongly encouraged to attend the weekly Family Night programs and to participate in family counseling sessions. A variety of skills groups address family issues including improving communication, dealing with family members who use substances, how family members can be supportive of the adolescent's recovery, issues of autonomy and independence, and how the adolescent might earn back trust from his or her family. Counselors try to maintain weekly contact with family members in order to address any concerns they may have and to encourage involvement in their son's or daughter's treatment process. At this time, very few family sessions take place in the adolescent's home. Most family work occurs at CHS, over the telephone, or through correspondence.

Structure and consistency are identified as parenting techniques that can provide support for the adolescent substance abuser in recovery. The importance of this parenting approach is stressed in family counseling sessions and in the Family Night program. Parents are encouraged to set limits and to follow through with consequences. Most importantly, parents are taught to reinforce positive behaviors rather than rely on punishing negative behaviors to effect change in the adolescent.

Collateral (Non-Family) Education and Involvement

Adolescents with substance abuse problems can be creative and manipulative when they try to maintain their substance use. It is critical that collaterals work together toward the same goals. Collaterals may include parents, family friends, probation/parole officers, school counselors and teachers, family physicians, family mental health professionals, and mental health facilities from which the adolescent was referred or to which the adolescent will be referred on completion of treatment at CHS. When the counselor and collaterals work together, it results in a more consistent treatment. For example, it can increase the immediacy of rewards and consequences since all involved parties will be aware of the adolescent's progress and difficulties.

Contact is maintained with collaterals in a variety of ways including family counseling sessions, meetings, telephone calls, and letters. One important procedure for communicating with collaterals is the "Weekly Checksheet" which is completed by counselors on each adolescent (see sample at end of the chapter). The Weekly Checksheet includes information on group attendance and level of participation, behavioral stability, if a urine screen was left and the results, any family involvement, and a short summary of the adolescent's progress for the week. The checksheets are mailed to all collaterals for whom there are valid disclosure authorizations.

Urine Screens

CHS adolescents have consistently reported that the collection of urine screens is a strong deterrent to substance use. Urine screens can be used as concrete evidence of positive change (i.e., a clean screen), as well as an indicator that the adolescent has been unable to stop using (i.e., a positive screen). In general, IOP adolescents are asked to leave screens every week and OP adolescents every two weeks. Staff make it clear that urine screens can be collected at any time.

Urine screens are only one piece of information that address the issue of substance use. Since tampering with urine screens is common and they are not 100% accurate, urine screen results are used in conjunction with other information to assess whether it is likely that an adolescent is or is not using. A change in behavior (e.g., increased irritability, missing groups, violating curfew) and/or attitude at CHS or at home are often indications of substance use. While urine screens have shortcomings, they can be used to motivate an adolescent to stop using.

Promoting a Structured Environment

Developing and maintaining a structured environment functions as a change mechanism in the recovery process. A structured environment facilitates change by providing activities, alleviating boredom, creating goals, and encouraging responsible behavior. The counselor, parents, and other collaterals can all work together to change the environment.

Structure in daily life can be increased with leisure activities, employment, attendance at school, AA/NA meetings, or treatment groups. Structure can also be increased by simple activities like setting up regular times to get up or go to bed. Participation in structured activities not only provides buffers against boredom, but can also help the adolescent meet daily, weekly, and monthly goals. Setting and achieving goals can effect positive change in an adolescent's self esteem and self-efficacy. As an adolescent grows more confident in his or her ability to maintain sobriety, new habits are learned and more responsible behavior becomes the norm. Counselors help adolescents develop schedules of activities and then follow up with adolescents to determine if they have been successful at incorporating more structure into their lives.

The CHS OP program is a structured environment. The counselors try to be predictable, consistent, and organized. For example, CHS rules are printed and reviewed with all adolescents upon admission and about once a month in a group setting. Making the rules explicit (i.e., defining adolescent expectations) creates structure. We have learned that if staff do not consistently enforce the rules, some adolescents may then push the limits and test other staff members, making it difficult to maintain order and structure. Consistency must, by definition, be supported and provided by all involved staff. While maintaining structure and consistency appears helpful to all adolescents, it is particularly important and therapeutic with conduct-disordered adolescents.

Homework

Since an adolescent is at CHS for a relatively brief period each week, it is considered good practice to give "homework" assignments that will encourage working on recovery goals on a daily basis. Assignments should be attainable, objective, and presented in a way that demonstrates how treatment goals relate to the real world. Assignments might include eating one meal a day with their family, writing their substance use history, completing a specific number of job applications, spending time with siblings, or making one new non-using friend. It

is important to "set the adolescent up" for success. Adolescents are asked to rate their self-efficacy concerning accomplishing the assignment. If it is low, the counselor helps the adolescent figure out what they need to do in order to be successful and the impediments to successfully completing the assignment. Homework assignments are appropriate for families as well as individuals.

Promoting Social Supports

While the adolescent is ultimately responsible for his or her own behavioral or emotional changes, the counselor and other OP staff can facilitate, encourage, and guide (i.e., motivate) the adolescent down the path to recovery. Social supports can decrease the risk of relapse. Recovery is a long and difficult process that often involves loss of old friends, and it is particularly difficult for adolescents to accept that they need to avoid old drug-using friends. Success is very difficult to achieve if the adolescent does not replace or avoid old friends and activities. For this reason, a relatively large number of skills groups address peer relationships, recreation/leisure activities, becoming involved in clubs or school activities, coping with cravings, and identifying people and organizations who are supportive of a recovery lifestyle.

Several skills groups provide information on AA/NA/CA meetings and their philosophy of recovery. Many adolescents are encouraged to regularly attend these self-help meetings on a weekly basis and obtain a sponsor. Approximately once every two or three months, CHS staff transport the adolescents to an AA, NA, or CA meeting during scheduled group times. Although not all adolescents are appropriate for ongoing AA/NA/CA involvement, staff feel it is important that all adolescents be exposed to self-help meetings and understand how the meetings have helped a large number of recovering people.

Another social support system involves school personnel. Some adolescents have developed trusting relationships with teachers and/or counselors. In these situations, adolescents are encouraged to regularly meet with these school staff members. With the adolescent's permission and a valid disclosure authorization, the Weekly Checksheets (treatment progress reports) are mailed to the respective teacher, SAP specialist, or counselor. Since CHS counselors are in 22 schools in and around McLean County, the OP counselors regularly talk with these counselors about the respective adolescent's progress and difficulties.

Adolescents may have physical or emotional problems that are treated by family physicians, psychologists, or psychiatrists. Maintaining contact with these professionals also helps foster a supportive network. In talking with them, OP counselors emphasize the adolescent's need for monitoring and direction as they develop a recovery lifestyle. It is common that non-substance abuse professionals are unaware that the adolescent is being treated for substance abuse. By helping these professionals understand adolescent issues, they can provide additional social support for sobriety/abstinence.

Fostering Staff Cohesiveness

Two related goals of the OP/IOP program coordinator are to develop a sense of camaraderie among staff and foster a team approach to treating adolescents. These goals are addressed through staff meetings, individual supervision, yearly retreats, informal social gatherings, and locating staff offices close to one another. Closely located offices tend to encourage consultation. This helps counselors feel more comfortable with difficult decisions. When one counselor asks another counselor for help and support, this helps validate the second counselor's job skills. The program coordinator is also available for staffings throughout the week.

The program coordinator leads all staff meetings held every Monday (one hour) and Wednesday (two hours). The main agenda of staff meetings is presenting and reviewing adolescent progress. Counselors update other staff on adolescent issues. Strategies are developed to address specific adolescent issues. Thus all staff can be sensitive to particular adolescent needs including personal issues, problematic behavior, the need to leave a urine screen, or prompting an adolescent to address a specific MTP goal he or she had agreed to talk about in a group. Working as a team requires that all staff have knowledge about all of the outpatient and intensive outpatient adolescents, not just their own clients. This shared knowledge allows for a more consistent and supportive treatment environment.

Staff meetings provide excellent opportunities for the program coordinator to role-model asking for help/input and to create a sense of identity for the program as a whole. One way a sense of identity and accomplishment is cultivated is by presenting group data (e.g., number of family or individual sessions completed, number of group hours provided, number of

clinical recor deficiencies). By presenting data on a monthly basis, goals are generated for the comin month Emphasis is placed on working as a team to improve performance.

Collaborating with Others

Since adolescents are often involved in multiple systems, their substance abuse treatment needs to be a collaborative effort involving all professionals who have contact with the adolescent. The counselor ensures that the collaterals are involved in the adolescent's treatment process and kept informed about the adolescent's progress. The first step in this process is to identify important collaterals. The CHS evaluation includes completing the GAIN-I. This instrument assesses a wide range of problem areas that identify collaterals. The evaluator can then complete disclosure authorizations early in the treatment process and obtain information when appropriate. While coordinating treatment often can be time-consuming and frustrating, more often than not collaterals are willing to share in the adolescent's treatment program and provide information and support. Contact is maintained through phone calls, shared reports, mailed Weekly Checksheets, and meetings. Counselors are encouraged to maintain contact with collaterals on a weekly basis.

Weekly contact is most often maintained with the family, legal personnel, and school counselors. Other collaterals include substance abuse or psychiatric facilities, physicians, and managed care organizations. Contact may occur only initially or as needed. The following is a description of various types of collaterals and the relationships that counselors typically try to maintain with them.

Working with Family Collaterals

Working with an adolescent's family is a goal that CHS counselors always address in MTPs. As noted above, counselors begin fostering this relationship during the admission process when at least one parent/guardian is usually present. The admission is viewed as the first family session. Both the adolescent and family are asked to formulate treatment goals. The counselor then incorporates their goals into the MTP. The goals are written in an objective and attainable manner. For example, attending family counseling sessions may be the vehicle through which the family is given the opportunity to address certain goals (e.g., getting along

better/decreasing arguments, determining appropriate consequences when the adolescent violates house rules, understanding why the adolescent uses).

Preliminary data from 50 Adolescent Treatment Model (ATM) study participants indicated that 58% of adolescents have single parent families, 25% reported weekly alcohol use in the home, and 8% reported weekly drug use in the home. Over 70% reported first using drugs or alcohol before the age of 15. Increases in life problems have been associated with earlier onset of substance abuse. At intake, 42% of adolescents reported weekly family problems. The percentage of adolescents reporting weekly family problems dropped to 34% at three months and 28% at six months after admission.

Family interventions include counseling sessions, the Family Night program, weekly contact through phone calls, mailing Weekly Checksheets to the family, and meetings with other collaterals such as probation officers. The outpatient coordinator strongly encourages the counselor to be persistent in trying to involve families in the treatment process. Both staff meetings and individual supervision sessions provide opportunities to emphasize family involvement and reinforce successful attempts at involving families. Counselors are expected to offer a family counseling session at least once a month. In reality, some families attend more than one session per month and others do not attend any sessions. Sometimes probation officers can be enlisted to apply pressure for family involvement. When contact is minimal, it is very important that the counselor help the parents identify any positive changes that the adolescent has made. Phone calls and Weekly Checksheets are sometimes the only avenues available to involve the family in the adolescent's treatment program.

Working with Legal Collaterals

About 70% of the OP and IOP adolescents are involved in the criminal justice system. Around 60% of ATM adolescents who self-reported meeting dependence criteria also met criteria for conduct disorder. Next to family, legal personnel (e.g., parole officers, probation officers, court supervision officers) are the most common collaterals with whom counselors maintain regular contact. The legal system often provides much needed leverage in "helping" adolescents decide to follow through with treatment recommendations. In general, legal officers are supportive of CHS recommendations and are interested in their adolescents' progress and difficulties. Court officers will address treatment issues individually with an adolescent and give

consequences when the adolescent is not compliant. Meetings sometimes address scheduling issues and how to provide structure for the adolescent. For example, some adolescents are in legal programs that meet at the same time as their CHS scheduled groups. In other cases, an adolescent may have to serve jail time or the adolescent is court-ordered to attend alternative school or GED classes, and the school hours are during treatment group hours. Adolescents often have many demands placed upon them, and it is critical that the professionals help adolescents develop a manageable schedule.

Communication between court officers and CHS counselors occurs through telephone calls, e-mails, meetings, and reports. Legal systems frequently have comprehensive, detailed information on the adolescent and their family, which is provided to CHS. Likewise, CHS sends assessment/evaluation reports and discharge reports to court officers. Also, Weekly Checksheets are sent to probation. These sheets provide a weekly summary of the adolescent's progress. Court officers are most interested in the adolescent's attendance record and the results of urine screens. The checksheets provide this information. Meetings with the court officer, the adolescent and their family, and the counselor generally occur at CHS or at the probation department.

It is common for the court officer to tell the family what they must do to support the adolescent's treatment experience. Parents are sometimes court-ordered to attend the Family Night program and to immediately call the officer if the adolescent violates any of the terms of probation in the adolescent's court order. Expectations are clearly identified and responsibility is placed on both the adolescent and parent(s). While this sometimes results in angry parents as well as angry adolescents, it also tends to increase attendance in the Family Night program. A common issue addressed during Family Night sessions is anger that the parents have towards the legal system. Counselors work with the families to help them accept what they cannot change, as well as recognize their adolescent's responsibility for his or her legal status. These discussions also provide an opportune time to help adolescents see that their using and illegal behaviors have significant negative effects on other people.

Counselors may write letters for presentation in a court hearing for the adolescent. These letters are typically a short synopsis of the adolescent's progress. Judges want to know that the adolescent is participating in treatment, attending groups, and leaving clean screens. If an adolescent is appearing before a judge because of positive screens or other treatment violations, a

recommendation is included in the letter (e.g., continue in treatment, discharge from treatment and follow through with legal obligations, discharge or transfer to residential treatment if the adolescent does not change their problematic behavior within a specified time period).

Because legal systems are major referral sources, the case managers also maintain frequent contact with the officers. The case managers lead drug education skills groups at three probation departments and complete screenings at many probation offices. These services promote closer relationships with the officers and hopefully with the adolescents, some of whom become CHS adolescents. The case managers often initiate the collaboration process with court officers, and they provide updates to officers about the adolescent's progress.

Counselors, case managers, and other staff are sometimes subpoenaed to appear in court, as many CHS adolescents are involved in the legal system. The Federal Confidentiality Laws and Regulations (42 U.S.C. 290dd-2, 45 CI F.R. Part 2) prohibit treatment programs from disclosing information concerning current or former clients in response to subpoenas, with two exceptions: (1) the adolescent provides written consent authorizing the program to release information; or (2) the court orders the program to release information after determining that good cause exists under the laws and regulations to issue an order. No subpoena is ignored, as failure to respond can result in a fine or time in jail. Subpoenaed employees have the opportunity to obtain the necessary authorization from the adolescent to testify, or to contact the court and inform them that they cannot release information without the adolescent's authorization or a judge's orders.

Working with School Collaterals

Coordinating services with schools helps counselors gain a more complete picture of an adolescent's recovery lifestyle. Initial ATM data indicated that 93% of adolescents are either in school or GED classes, and about a third report experiencing school problems. At six-month follow-up, only 12% of these adolescents reported school problems (Godley et al., 2001).

CHS has SAP staff at 22 schools in McLean County and the surrounding area. It does not have staff at local GED programs or the alternative schools. Adolescents who attend a school with SAP staff (a large proportion) are strongly encouraged to contact the SAP specialist at their school. An SAP specialist, who is knowledgeable about substance abuse and related issues, can meet regularly with a student and provide support services.

In order to ensure that SAP staff are aware of all CHS adolescents who attend their schools, the evaluator completes a form with adolescent and school information during the initial evaluation process. This form is sent to the SAP coordinator. The SAP coordinator then gives the form to the appropriate SAP specialist so he or she can follow up with the adolescent. This procedure appears to significantly increase the level of communication between SAP specialists and the OP counselors.

CHS counselors send the adolescent Weekly Checksheets to the respective SAP specialist for every adolescent in an SAP school. SAP specialists often send or call the counselor with adolescent/student information. Because adolescents often do not report school problems or even school progress, these contacts are very helpful. Since most adolescents have MTP objectives addressing school goals, it is important to gain accurate information regarding school performance. A common MTP goal is for the adolescent to maintain contact with the SAP specialist. The school environment is frequently a place where adolescents have used substances, so they are very much in need of social supports in this environment. Also, several SAP specialists have support groups in their schools that meet on a weekly basis.

Working with Other Treatment Facilities (Substance Abuse, Mental Health, Hospitals)

Collaboration with other treatment facilities most often occurs at the beginning of an adolescent's treatment experience. When an adolescent is referred for treatment by another facility, the typical evaluation process is followed. The prospective adolescent client is scheduled for an evaluation. Reports containing diagnoses, recommendations, and treatment progress are requested from the referral source. If an adolescent was a previous CHS adolescent within the last six months, a new GAIN-I is generally not completed. Often the adolescent is assigned to his or her previous counselor. The counselor completes an assessment update. Information is gathered from the last date of contact with CHS to the present. If over six months have passed since the last date of contact, the counselor is required to write an evaluation (biopsychosocial) report that addresses the interim since their last contact with CHS.

If an adolescent continues to receive services from the referral source (e.g., family counseling, medication management), contact is maintained throughout the adolescent's treatment experience. For example, a family doctor may have prescribed Ritalin for Attention Deficit Hyperactivity Disorder (ADHD). The adolescent's MTP would have an objective stating

that the adolescent would follow the doctor's recommendations and that the adolescent would be monitored for ADHD symptoms while at CHS. However, once admitted to CHS, most adolescents do not receive services from the referral source.

When an adolescent is discharged unsuccessfully and residential treatment is recommended, discharge reports are often sent to the guardians. The guardians can then provide the reports to the residential facility of their choice. If the adolescent chooses to complete residential treatment at CHS, the records are readily available to the residential counselor. In this case, the OP counselor often spends time with the residential counselor and provides clinical information about the adolescent and their family. Also, the OP counselor is able to maintain contact with the former adolescent since the programs are in close proximity. When adolescents complete residential treatment, they return to the OP program and their previous counselor for aftercare services.

Working with Medical Collaterals

Adolescents may enter treatment with medical problems that are being treated by a family physician. ATM data indicated that of the adolescents who self-reported meeting dependence criteria, 54% reported health problems. Since most illnesses and physical problems can be adversely affected by substance use, it is very important to address medical issues in the adolescent's MTP. Contact with medical collaterals is usually initiated and maintained by telephone. Physicians are most interested in the adolescent's urine screen results and any medications that might be prescribed by a psychiatrist. The CHS psychiatrist is also alerted to any prescription medications the adolescent has been prescribed so that she can assess for possible drug interactions.

Working with Managed Care

When adolescents have insurance coverage for substance abuse treatment, the CHS counselors maintain regular contact with the insurance company. While most telephone calls last 10 to 15 minutes, they sometimes last up to an hour. Initially, an in-depth clinical profile of the adolescent is often required. The counselor is asked to provide information that justifies the treatment recommendation. Since few OP and IOP adolescents meet "medical necessity" criteria, ASAM guidelines provide the framework for justifying placement in treatment.

Occasionally, a counselor is required to also talk with a medical doctor or psychiatrist in order to obtain insurance coverage. In most cases, only one or two weeks of treatment is authorized or covered by the managed care person. Then, either telephone calls or paperwork every few weeks are required to obtain additional coverage.

Because CHS receives State of Illinois Office of Alcoholism and Substance Abuse funding, grants are available to help pay for treatment for most financially eligible adolescents. However, counselors must attempt to obtain insurance coverage prior to accessing grant money. Adolescents and their guardians meet with the financial intake person when they are admitted into treatment. Both insurance information and grant eligibility information are obtained at that time.

While managed care personnel are not typically considered collaterals, it is important for counselors to spend time addressing their questions. Insurance dollars help offset costs for adolescents with Public Aid coverage and adolescents who fail to pay their portion of treatment costs. It is in the adolescents' best interest that we obtain insurance dollars since CHS can then invest in the highest possible quality care.

Addressing Critical Treatment Issues/Special Services

Developmental Issues (Age)

Program staff are sensitive to an adolescent's age when determining the appropriate treatment plan. Since chronological age is not always as important as developmental age, an adolescent's level of functioning is determined through both observation and collaborative reports. When younger adolescents are mocked by older adolescents, counselors are trained to intervene early and try to engage older adolescents to be positive role models and supportive of the younger adolescents. Staff have also learned that younger adolescents tend to profit from increased individual attention.

Race/Ethnicity

While our treatment populations are primarily white (as is the population in the county), the program serves a higher proportion of African Americans than in the general population base. When recruiting new staff, an attempt is made to recruit individuals from different ethnic and cultural groups. In 1999, in order to be responsive to a small, but growing percentage of

Hispanics in our community, the program created a Latino outreach position. The Latino outreach program works to engage and retain Latino youth in need of treatment. In addition, both African American and Hispanic presenters are brought in to speak with the adolescents about recovery and related issues. Adolescent retention data suggest that the OP/IOP programs have been successful in retaining members of minority groups in treatment.

Cultural Appropriateness

Cultural issues are relevant to nearly all adolescents in treatment in that substance use will eventually immerse adolescents in the culture of addiction (White, 1990). The culture of addiction involves many aspects of adolescents' lives. The clothes and jewelry they wear, how they talk and what they talk about, with whom they associate and how they interact, activities in which they participate, and their values and goals can all be strongly influenced by the culture of addiction. Through discussion, adolescents' awareness of these cultural issues is heightened. As described above, CHS has staff members from several ethnic groups who can serve as consultants on cultural appropriateness. In addition, staff are always encouraged to participate in cultural sensitivity training.

Language

Almost all of the adolescent population in McLean County is fluent in English, but if an adolescent is not, an appropriate interpreter will be retained. CHS's Latino outreach worker is fluent in Spanish and English.

Gender Issues

The current OP, IOP, and residential programs have skills and therapy groups that are gender specific. Since SAP services typically consist of individual sessions, gender issues also are dealt with in those sessions. The GAIN battery has measures related to victimization, sexual orientation, HIV-related risk behaviors, and other gender specific issues which alert counselors to these issues. CHS is required by the State of Illinois to address these types of issues in each adolescent's individual treatment plan.

Sexual Orientation

When an adolescent in any level of treatment expresses a sexual preference for the same sex, staff begin by talking with him or her individually. Staff have found that most adolescents in this community are fearful that their peers will not be accepting of an alternative lifestyle, so they may not feel comfortable talking about their sexual orientation in a group setting (hence the individual therapy). Currently, the program has several diversity-focused groups, which discuss the importance of accepting others who are different. In addition to individual counseling while they are in treatment, these adolescents are also referred to specific self-help groups in the community.

Disability

No adolescent is denied treatment due to any disability, and the program consults with the local Center for Independent Living in addressing any special needs. For example, the program has provided interpreter services so that deaf parents could attend the Family Night program.

Dual Diagnosis Issues

Adolescents who have or who are suspected of having psychiatric issues are referred to CHS's consulting child and adolescent psychiatrist who is onsite two days per week. The psychiatrist also serves as a consultant to counselors regarding particular adolescents. Counselors have the opportunity to review written psychiatric assessment reports on adolescents that the psychiatrist assessed. When an adolescent is prescribed psychotropic medication, counselors work with the psychiatrist and family members to enhance medication compliance. Family members are involved and educated regarding the important role they can play in encouraging medication compliance.

Hepatitis, HIV, and Tuberculosis Prevention, Testing, and Treatment

Hepatitis, HIV, and tuberculosis (TB) prevention and education programs are incorporated into treatment. The program uses educational videos as well as selected activities from a curriculum that has been approved by the Centers for Disease Control and Prevention (CDC): *Be Proud! Be Responsible!* (Jemmott et al., 1999). This curriculum is based on social

cognitive theory, the theory of reasoned action, and the theory of planned behavior. Both test decision counseling and HIV testing are available, optional, and free of charge. The test decision process includes a problem solving approach that helps adolescents identify their risks and future prevention options. In all adolescent programs at CHS, approximately 150 youth annually ask to participate in test decision counseling and about half of those choose to be tested for HIV. The CDC and the Illinois Department of Public Health guidelines for test decision counseling are followed, and both blood and oral HIV testing are offered. As required by state law, all test results are confidential, and this information is not placed in the adolescent's clinical record. If an adolescent tests positive for HIV, the HIV counselor would continue to meet regularly with him or her for education and counseling with the goal of linking the individual to appropriate crisis services, medical care, and HIV case management services.

Other Medical Services

When adolescents are admitted to treatment, they complete a health history questionnaire with the counselor. The counselor notes any significant medical problems, particularly any that might affect an adolescent's treatment experience. If an adolescent has a communicable disease such as TB or any other airborne pathogen, he or she cannot participate in treatment with other adolescents because of the risk of infection. If known, bloodborne pathogens such as HIV or sexually transmitted diseases would be addressed during the treatment process, but would not keep an adolescent from participating in treatment. All CHS staff are trained in universal precautions concerning blood spills and are required to complete yearly TB tests. Flu shots and Hepatitis B vaccines are offered to staff, and the CHS nursing staff are available for any questions and concerns. This helps promote a healthy work environment and ensures the safety of both adolescents and staff.

All adolescents are encouraged to complete a physical examination with their family physician if they have not recently done so. It is explained to the family that adolescent substance abusers have a higher than normal occurrence of physical problems, and that for this reason a physical examination is encouraged. Adolescents and their guardians are made aware that the CHS physician can complete a physical examination.

Medical issues are noted on ASAM Dimension II in the MTP. The most common medical problems include asthma, other respiratory problems, vision problems (needs glasses),

and gynecological issues including pregnancy. Adolescents and their guardians are strongly encouraged to seek appropriate medical services for medical problem(s) from their family physician. Since some medical problems cannot be resolved while the adolescent is in treatment and will need to be addressed after the adolescent leaves treatment, the family is encouraged to use their family physician. If an adolescent is pregnant, the CHS counselor facilitates referrals to services that address prenatal care and parenting classes. CHS typically does not maintain contact with these referral sources. All adolescents receive education regarding sexually transmitted diseases and, as noted above, hepatitis, HIV, and TB. Adolescents can talk with the HIV counselor about any issues related to sex, either in a group setting or on an individual basis. The HIV counselor can also make referrals for the adolescent.

We find that most adolescents are accepting of education linking substance use with exacerbation of physical problems. If the adolescent receives services from the CHS psychiatrist, the psychiatrist also emphasizes that psychiatric medications are not effective if the adolescent continues to use alcohol and/or illicit drugs. Discussion of these issues increases the adolescent's motivation and willingness to move toward abstinence as a treatment goal.

Learning Disabilities and Literacy

Many of the CHS adolescents have learning disabilities and/or have had difficulty in school. Staff attempt to be sensitive to these issues and make the necessary accommodations in skills groups and individual sessions. On-site school is available for those in residential treatment.

Onsite General Equivalency Diploma Classes

Adolescents in all levels of care can attend General Equivalency Diploma (GED) classes that are conducted at CHS. GED classes are presently held from 9:30 a.m. to 12:30 p.m. Monday through Thursday throughout the regular school year. The GED teacher is provided by the Regional Office of Education. When the GED teacher feels that an adolescent is ready to take the GED test, the adolescent is scheduled to take the test and a $25.00 fee is paid. The final test is offered about four times per year.

Educational goals are strongly emphasized and encouraged for both residential and OP adolescents. Some adolescents have either been expelled or dropped out from regular school.

Their alternative at this time in their lives is to obtain a GED. OP counselors regularly assess an adolescent's progress toward obtaining a GED. MTP educational goals address typical school problems such as truancy, tardiness, and maintaining passing grades. When an OP adolescent earns a GED, the occasion is celebrated and reinforced through recognition and having a "party" during OP group time. Helping adolescents achieve personal goals such as obtaining a GED fits with therapeutic goals and coincides with CHS's mission statement.

Transportation Services

Transportation is provided to adolescents who are in need of a ride to and/or from treatment groups. A typical situation might involve an adolescent whose parent works until 5 p.m. CHS would pick up the adolescent either at home or at school. The parent would pick the adolescent up at CHS after groups at 7 p.m. Sometimes adolescents need to be transported for only a week due to a particular situation, such as when a parent is out of town for a business trip. On average, three or four adolescents need rides at any one time. On rare occasions, when it is not possible to pick up all adolescents in need of rides, adolescents may be provided with bus tokens. CHS is fortunate to have a city bus service that has a bus stop at the front door of the facility.

Although adolescents are almost always picked up from their home or school, an adolescent can be picked up from any location as long as the guardian gives permission. Adolescents are expected to work with their counselor and set up a schedule for transportation if the need is ongoing. If an adolescent who is typically not transported needs a ride, the adolescent is expected to contact CHS no later than 2 p.m. Groups start at 4 p.m. If at all possible, CHS will pick up the adolescent.

The task of transporting adolescents is usually the duty of the part-time OP counselor assistant. He or she uses a company vehicle. However, there are times when counselors pick up adolescents. This might occur when there are too many adolescents to be picked up by one person, and two vehicles are used. Another situation in which a counselor might transport an adolescent is when an individual session is scheduled in the morning hours and that adolescent has no transportation to CHS. The OP counselor assistant who provides transportation works part-time and is only available in the afternoon and evening.

Outside Referrals

Providing comprehensive treatment that addresses all problem areas sometimes involves referrals to other agencies and/or professionals. The assessment process attempts to identify all adolescent needs. It is the counselor's job to address all identified needs. Please see the section in this chapter titled, "Collaborating with Other Service Providers." Not only are typical collaborators identified, but referral sources are also discussed. Most referral sources also function as collaborators in the adolescent's treatment program.

12 Step Meetings

Self-help meetings and the 12 Step philosophy are incorporated into all adolescents' treatment experience. Nearly all adolescents are expected to attend at least two meetings, and many adolescents are expected to attend meetings on a weekly basis. The Bloomington-Normal community has over 100 AA, NA, and CA meetings each week. The adolescents participate in skills groups that address how self-help meetings can be beneficial to their recovery process. The 12 Step philosophy is also explained to the adolescents, with particular emphasis on acceptance, denial, honesty, and the concept of a Higher Power.

Adolescents are transported to a local AA or NA meeting about once every two or three months. CHS staff do not attend the meeting with the adolescents, but only transport them to and from the meeting. When the adolescents return to CHS, a counselor leads a discussion on adolescent impressions of the meeting. It is important to let the adolescents know that self-help meetings are probably not appropriate for all adolescents, but that self-help meetings are one of the most successful components of recovery for many people of all ages. Adolescents who have completed residential treatment are generally the most receptive to incorporating self-help groups into their recovery process. Adolescents are given "verification slips" by CHS staff that can be signed by the self-help chairperson in order to confirm their attendance at a meeting.

Developing social support systems is often a difficult task for adolescents. Most self-help meetings have relatively few adolescents in attendance, and this is a significant deterrent/excuse to not attend. Several self-help meetings are held each week at the adolescent CHS facility that are "regular" (i.e., open to the community) meetings. Since the CHS residential adolescents attend these meetings, there is a relatively high number of adolescents in attendance. OP and IOP adolescents are encouraged to attend these meetings.

One of the ten Family Night programs is devoted to self-help groups. Families learn about 12 Step concepts and how they relate to their son's or daughter's recovery. Family members and friends are encouraged to attend Families Anonymous. Families Anonymous uses the same basic philosophy as AA/NA/CA, but the focus is on detachment and enabling. Parents and guardians learn how to set limits, follow through with consequences, accept what they cannot change, and place the responsibility for the adolescent's behaviors on the adolescent by letting natural consequences occur. They also learn the importance of taking care of themselves by not letting the substance abuser control their behaviors and emotions.

Evaluation of Adolescent Progress in Treatment

Adolescents are told at the beginning of treatment that their progress will be measured by completion of treatment plan activities and through the achievement of the goals in their treatment plan. Progress on the MTP objectives is reviewed at least once every 14 days with IOP adolescents and every 30 days with OP adolescents. MTP reviews also occur when additional goals/objectives are added and/or there is a change in diagnosis. Both the adolescent and the counselor sign their names to indicate that the review took place. These are opportune times to help the adolescent see any positive changes, however small, that he or she has made. Encouragement and hopefulness are powerful motivators that the counselor can use in promoting change in the adolescent. When adolescents complete their goals, they are successfully discharged ("As Planned") from that treatment level. They may be transferred from one level of treatment to another based on their needs and progress. For example, if the adolescent is not able to abstain from substance use while in OP, the treatment team may recommend a transfer to IOP for more intensive services. Typically, as the adolescents complete their goals and progress through treatment, their group schedule is slowly reduced to allow a gradual transition out of treatment.

EXAMPLE MTP

CHESTNUT HEALTH SYSTEMS	CD TREATMENT PLAN PART II-IV

Staff Involved in Treatment Plan Development:

	A. Sodetz, PhD. Clin Dir.		S. Oberst, BSW, CADC, Coord. Curr. Instr.
	L. Adams, LCSW, Dir/Youth Services		J. Quinn, BS, CTRS, Rec. Ther.
	L. Dowden, MD, Consulting Phys.		L. Morrison, MS, CADC, Intake Coord.
	M. Kenney, MS, LCPC, Res. Coord.		S. Beecher, BA, Case Manager
	G. Miller, MS, LPC, LCPC, Asst. Coord.		R. Harvey, MA Candidate, Case Manager
	M. Brennan, BA, Asst. Coord.		A. Mueller, MA, LCPC, Case Manager
	A. Duback, MSW, Ad. Ther.		K. Nafziger, BS, Case Manager
	K. Fosnot, MS, LPC, Ad. Ther.		R. Risberg, MA, CRADC, LCPC, OP Coord.
	K. Luckey, MS, LCPC, Ad. Ther.		D. Carter, MS, MSW Candidate, OP Ther.
	T. McQuirter, BS, CADC, Ad. Ther.		K. Maquet, MS, LCPC, OP Ther.
	M. Mercer, MS, LCPC, Ad. Ther.		J. Stogdell-Koehler, MSW, LCPC, OP Ther.
	R. Muhammad, MA, Ad. Ther.		J. Estrada, Latino Youth Interventionist
	M. Simmons, CADC, Ad. Ther.		
	M. Skupnick, M. Div, Ad. Ther.		
	C. Warfield, MS, CADC, Ad. Ther.		
	M. Williams, MS, Ad. Ther.		

DATE	STRENGTHS/WEAKNESSES	AS PERCEIVED BY:		
		PATIENT	FAMILY	STAFF
1/18/02	STRENGHTS			
	1. Intelligent	X	X	X
	2. Athletic	X	X	
	3. Friendly	X	X	X
1/18/02	WEAKNESSES			
	1. Addicted to substance	X	X	X
	2. Can be disrespectful	X	X	
	3. Makes poor decisions at times	X	X	X

Initials/Signature Key:

Patient Name: John Doe	**Patient Number:** 012345

CHESTNUT HEALTH SYSTEMS	CD TREATMENT PLAN PART II

Chestnut Health Systems employs a "Psychosocial" philosophy of substance abuse/chemical dependency treatment. As such, it is our belief that all individuals, regardless of diagnosis or severity of chemical problem, can benefit from being exposed to a basic core of skills necessary for leading a substance free or mentally healthy lifestyle. Therefore, patients in all levels of care will be encouraged to attend groups or individual sessions and complete paperwork to develop the following skills:

TREATMENT	FREQUENCY	MODALITY	
	FREQUENCY	GROUP	INDIVIDUAL
Assertiveness Skills	Two times per week	X	
Decision-Making Skills	Two times per week	X	
Stress Management Skills	Two times per week	X	
Coping Styles Awareness	One to two times per week	X	
Relapse Prevention/Habit Control Skills	One to two times per week	X	X
Leisure Activities/Planning	One time per day	X	
Self-esteem Enhancement	One to two times per week	X	
Basic Health and Hygiene	One time per week for six weeks	X	
Medical Aspects of Drug and Alcohol Use	One time per day for ten days	X	
HIV/AIDS/TB Prevention Education	One time	X	
Nicotine Dependence	One time	X	
Family Participation	When possible	X	X
Self-help Attendance and Participation	Seven times per week	X	
Spirituality	One time per week	X	
Budgeting/Financial Arrangements			
Time Management			
Employment/Interview Skills			

The degree of individual involvement and participation may vary and the topics discussed in each skills session will vary, but all patients will receive exposure in all of the above areas. These activities take place in a group format and individuals are expected and encouraged to address issues of personal relevance to each of them.

The patient and staff believe that the following family members/significant others should be involved in the patient's treatment.

_____ _____
_____ _____
_____ _____

Other individuals may also attend if, in the opinion of the patient and staff, it is determined appropriate.

TENTATIVE PASS SCHEDULE FOR YOUTH CD PATIENTS:

PASS NUMBER	HOURS	DATE COMPLETED
One	(4) 8 12 24	2/20/02
Two	4 (8) 12 24	3/1/02
Three	4 8 (12) 24	3/16/02
All others	4 8 12 (24)	3/31/02

CHESTNUT HEALTH SYSTEMS	CD TREATMENT PLAN PART III

SPECIAL CONSIDERATIONS: This portion of the treatment plan addresses those issues that are of special concern regarding participation in treatment but are not expected to be "resolved" prior to the patient being discharged or transferred to the next level of care, i.e. tutoring, medical issues, reading disability, etc.:

ISSUE	ACTION/HOW ISSUE TO BE ADDRESSED
1. Legal	John will attend any court dates as scheduled and will maintain contact with his probation officer.
2. Academic	John will have the opportunity to engage in academic activities while in treatment in order to obtain his GED.
3. Psychiatric	John will take his medications as prescribed.
2/12/02 – John has tried to contact his probation officer; he has attended school classes and done well in them; he has been taking his meds as prescribed.	Jane Counselor, MS
2/22/02 – Px same as above.	Jane Counselor, MS
3/6/02 – Px same as above.	Jane Counselor, MS
3/16/02 – John spoke to his probation officer today and told him he relapsed last week. John is also still working on his GED, but has failed his constitution exam twice. He's still taking his meds as prescribed.	Jane Counselor, MS
3/30/02 – John hasn't spoken to his probation officer since last time, but has continued to go to GED classes and he takes his meds as prescribed.	Jane Counselor, MS

CHESTNUT HEALTH SYSTEMS	CD TREATMENT PLAN PART IV

DIMENSION III: EMOTIONAL, BEHAVIORAL, OR COGNITIVE CONDITIONS AND COMPLICATIONS

PROBLEMS: John has difficulty maintaining emotional/behavioral stability.

MANIFESTED BY: Difficulty at home, with the legal system, and a history of psychiatric concerns.

GOAL: John will demonstrate the ability to remain emotionally and behaviorally stable by using effective decision-making and acceptance skills, and by following rules and laws which apply to him.

OBJECTIVES/INTERVENTION	**ASSIGNED** -program -staff	**TIMEFRAME** -frequency -length of sessions -target date	**DATE COM-PLETED**	**INITIAL**
John will have a psychiatric assessment and will follow any recommendations.	Counselor Medical staff	2/5/02 and throughout treatment	Assessed 1/22/02	J.C.
John will complete a list of reasons why he should stay in treatment and complete it successfully.	Counselor OP staff	1/24/02	1/24/02	J.C.
John will complete written treatment work related to decision-making.	Counselor	2/2/02	2/2/02	J.C.
John will complete written treatment work on depression.	Counselor	2/9/02	2/5/02	J.C.
John will complete written treatment work on anger management. He will make a list of ten anger triggers and ways to handle these. He will demonstrate these on a consistent basis to avoid physical and verbal aggression.	Counselor OP staff	2/20/02	2/16/02	J.C.
John will interview the nursing staff on the potential dangers of combining drugs and psychotropic medications, as well as how substance use could affect his depression.	Counselor Medical staff	3/10/02	3/8/02	J.C.
John will use counseling group to discuss his history of legal difficulties. He will identify the connection between his illegal activities and substance use, and will accept feedback on ways to avoid further legal difficulties.	Counselor	1/31/02	1/28/02	J.C.

DIMENSION V: RELAPSE, CONTINUED USE, OR CONTINUED PROBLEM POTENTIAL

PROBLEMS: John appears to have a limited awareness of his triggers for substance use and has difficulty abstaining from mood-altering substances when they are in his environment.

GOAL: John will identify relapse warning signs and relapse prevention strategies, including the development of a recovery plan, as well as demonstrate the ability to walk this recovery plan for 72 hours.

OBJECTIVES/INTERVENTION	**ASSIGNED** -program -staff	**TIMEFRAME** -frequency -length of sessions -target date	**DATE COM-PLETED**	**INITIAL**
John will complete a written account of his drug history and present this to staff and peers.	Counselor OP staff	2/15/02	3/1/02	J.C.
John will participate in groups and /or individual reviews of his substance thought journal entries to determine patterns.	Counselor	2/20/02 and throughout treatment	3/1/02	J.C.
John will complete written treatment work related to Step One of the AA program, present this in counseling, and receive feedback from peers.	Counselor	3/14/02	3/3/02	J.C.
John will develop and present a personalized plan for recovery in which he outlines alternative ways of dealing with needs met through using, a daily schedule, relapse warning signs, relapse prevention strategies, and demonstrate the ability to walk this plan for 72 hours.	Counselor	3/14/02	3/14/02	J.C.
John will leave urine screens and BACs which test negative for commonly abused substances and alcohol.	Counselor OP staff	As requested throughout treatment	3/30/02	J.C.

CHESTNUT HEALTH SYSTEMS	CD TREATMENT PLAN PART IV

DIMENSION VI: RECOVERY/LIVING ENVIRONMENT

PROBLEMS: John lacks a supportive family in his home environment as it is unstable. John's home environment lacks a non-using support system.

GOAL: John will improve communication through assertively expressing his feelings, develop a non-using support system, and come to tern to family use.

OBJECTIVES/INTERVENTION	**ASSIGNED** -program -staff	**TIMEFRAME** -frequency -length of sessions -target date	**DATE COM-PLETED**	**INITIAL**
John's family will be invited to attend the Family Night program and participate in group family counseling.	Counselor	Weekly throughout treatment	3/30/02	J.C.
John will compile a list of goals he has for himself in the next month, six months, and a year. He will identify how he is going to reach these goals and what could stand in the way of reaching these goals.	Counselor	2/28/02	2/22/02	J.C.
John will identify peers he has used with, who are negative, and who he has gotten in trouble with.	Counselor	3/10/02	3/1/02	J.C.
John will list people who will be supportive of his recovery and how he plans to utilize them in a supportive way.	Counselor	3/10/02	3/1/02	J.C.
John will identify safe and unsafe places in his home environment.	Counselor	3/15/02	3/10/02	J.C.
John will utilize counseling group to discuss his peers and how they are related to his usage.	Counselor	3/15/02	3/10/02	J.C.
John will assertively express feelings to family members during family sessions.	Counselor	Weekly throughout treatment	3/30/02	J.C.
John will discuss in counseling the relationship with his family and what he wants to be different.	Counselor	3/15/02	3/10/02	J.C.
John will write letters of goodbye to all his using friends, explaining why he can't hang out with them.	Counselor	3/28/02	3/28/02	J.C.

OBJECTIVES/INTERVENTION	ASSIGNED -program -staff	TIMEFRAME -frequency -length of sessions -target date	DATE COM-PLETED	INITIAL

OUTPATIENT GROUP SCHEDULE

Monday	Tuesday	Wednesday	Thursday	Friday
	Groups 10-12 Rick/Kelli		Groups 10-12 Rick/Kelli	
4-5 PM Counseling I Judi K. Counseling II Kelli	Self-Esteem Kelli	Working Recovery Judi K. HOW-I	Counseling Kelli	
5-6 PM Relapse Prevention Rick HOW II Joe	Family Group Judi K.	Counseling Kelli/Judi K.	Beginnings Joe	
6-7 PM Life Skills I Kevin Life Skills II Rick	Leisure Education Family Night Program 6:00 – 8:15 PM	Decision-Making Judy H.	Drug Education Judy H.	

WEEKLY CHECKSHEET

For the week of: March 11, 2002

Client Name: John Doe **DOB:** 01/01/85 **ID:** 012345
Scheduled date for individual session: 03/11/02 Attended? YES NO Rescheduled? YES NO

Rescheduled Date: _____ Comments: _____

_____

Scheduled date for family counseling session: 3/14/02 Attended? YES NO

Rescheduled? YES NO Rescheduled Date: _____ Comments: _____

_____

Scheduled days for group sessions: 3/11, 3/13, 3/15

Group comments: _____

_____

Family Night attended? YES NO Participants: _____

_____

		COUNSELOR			
MONDAY:	Counseling/Counseling	1	2	3	4
	Anger/Stress Management	1	2	3	4
	Relapse Prevention/HOW/Beginnings	1	2	3	4
	HOW/Beginnings/Relapse Prevention	1	2	3	4
	General Behavior	0	1		
TUESDAY:	Relationships/Self-Esteem	1	2	3	4
	Counseling (M)/Counseling (F)	1	2	3	4
	Drug Education	1	2	3	4
	Leisure Education	1	2	3	4
	General Behavior	0	1		
WEDNESDAY:	Life Skills	1	2	3	4
	Working Recovery/Decision Making	1	2	3	4
	Counseling	1	2	3	4
	General Behavior	0	1		
THURSDAY:	Emotions/Communication	1	2	3	4
	Relapse Prevention	1	2	3	4
	Counseling	1	2	3	4
	Art Therapy	1	2	3	4
	General Behavior	0	1		

Groups (Key)

4 Recovery oriented; relates topic to self; gives positive feedback

3 Attentive and participated in activities; respectful; understands topics

2 Disruptive; side conversations; continued rule violations; war stories

1 Did not attend; asked to leave; slept

Behavior Before, Between, & After Groups (Key)

1 Satisfactory (follows rules; respectful)

0 NOT Satisfactory (violates rules; smokes)

Was the client asked to leave a urine screen this week? YES NO Date screen left: _____

Date and results of last screen: 3/8/02 – negative THC

_____

Comments: _____

_____

_____

_____

_____

_____

Staff Signature: _____ **Date:** _____

V. Individual Work with the Adolescent

The CHS approach is based on the belief that individual counseling sessions are critical for building trusting relationships because they provide the opportunity for the counselor to give the adolescent personal attention and show unconditional positive regard. They also provide the best forum for developing an individual Master Treatment Plan (MTP) and for addressing individual issues that cannot be addressed in the group setting. However, it should also be noted that there are opportunities for counselors to address individual issues during skills and therapy groups. Group leaders are aware of individual issues because important clinical information about all adolescents is shared among staff members during staff meetings. Examples of individual issues that may be legitimately addressed in group settings include reinforcing individual adolescents for goal accomplishments and/or using an individual adolescent's example in discussion of a particular problem area.

Format for Individual Sessions

Individual counseling occurs in both formal and informal formats. Formal sessions are pre-scheduled with adolescents and typically last 35 to 45 minutes (the length of a group session). Informal sessions occur before, between, or after the skills or therapy groups that an adolescent is attending and last 10 to 15 minutes. Formal sessions take place in the privacy of the counselor's office. Informal sessions may occur in a hallway or office near the group session room.

When Individual Sessions Are Provided

Counselors are expected to see all adolescents individually at least once per month and to complete at least five hours of individual and/or family counseling each week. This level of individual work assumes a caseload of 15 to 20 adolescents. However, a counselor may have time constraints based on the make-up and number of adolescents in his or her caseload. In this case, the counselor is expected to discuss priorities for scheduling individual sessions in supervision. Frequently, adolescents are seen more than once per month depending on their needs.

Approximately 15% of OP adolescents participate only in individual and/or family sessions and do not attend groups. These adolescents may have histories of relatively minimal substance use, cognitive limitations, demonstration of the ability to maintain sobriety prior to entering treatment, or specialized needs (e.g., younger adolescents, gay youth). Counselors generally meet with an adolescent once per week, although it is not uncommon to have more than one session per week, depending on the adolescent's needs. Individual sessions with these adolescents do not differ significantly from the individual sessions described in this section. Adolescents who receive only individual counseling do tend, however, to receive more written homework, particularly related to relapse prevention skills.

Session Structure

Individual sessions may be very structured based on either the adolescent's or counselor's specific agenda. Examples of these interactions are developing treatment goals, addressing a positive urine screen, assessing for depressive symptoms, or re-stating consequences if negative group behaviors continue. How directive the counselor is can range from minimal to very agenda-oriented. Ideally, counselors are goal-oriented, which is directive in nature. There are times when the adolescent needs to talk and simply be listened to. Affirming and accepting the adolescent's feelings in this situation is an example of letting the adolescent define the agenda. The adolescent may define the agenda for the session when a counselor "checks in" with the adolescent and asks general questions about how he or she is doing. Sessions are often a combination of counselor-directed and adolescent-directed topics/issues. For example, a counselor may schedule time to discuss a positive urine screen. Adolescents may then use the time to discuss what led to the relapse and what they learned from the experience, incorporating information they learned in skills groups about relapse triggers and high-risk situations. The reverse situation can also occur, with the adolescent admitting to relapsing and his/her next urine screen testing positive. In this situation, the counselor helps the adolescent review what factors precipitated the relapse.

Individual Sessions During Different Phases of Treatment

The content of individual sessions will vary based on the phase of treatment an adolescent is in. The treatment episode can be divided into three main phases: initial, middle,

and final. The timeline for individual sessions is based on the typical OP adolescent who is in treatment for four to six months. Adolescents who are in IOP for four to six weeks—and are then transferred to OP—tend to enter OP in the "middle" individual sessions.

Initial individual sessions often focus on why adolescents are in treatment and their view of their problems. Adolescents often do not see their use of illegal substances as a problem. Counselors use active listening techniques and reflect adolescent feelings as a way of building a therapeutic relationship. Developing rapport can be difficult with adolescents, and CHS counselors are trained to take an approach in working with adolescents (i.e., collaboration) to help them achieve their goals. Goal development may begin with discussions about getting out of treatment, getting parents off their backs, or getting their freedom back. Counselors will also attempt to help adolescents see the relationships between specific goals, such as leaving clean urine screens and attending groups, and their goal of getting out of treatment. These discussions can lead to further dialogue about what the adolescent wants to change or have different in his/her life. At the next individual session, the goals will be further articulated and outlined in the MTP.

During the middle phase of treatment, individual sessions often involve reviewing the adolescents' progress (e.g., how they are maintaining sobriety, what they have learned in groups, changes in relationships with guardian or peers, and specific MTP objectives). Adolescents are encouraged to use counseling groups to address emotional issues. The counselor may let the adolescent know that they are aware of sensitive emotional issues such as abuse and grief issues, and that the adolescent can talk about this when ready. Other frequently addressed MTP objectives include family, peer, legal, and school issues, leaving urine screens as requested, AA/NA involvement, and changes in the adolescent's group schedule.

Final individual sessions, roughly those sessions occurring during the adolescent's last month of treatment, often focus on the adolescent being a positive leader/role model for the other adolescents in treatment and his or her recovery image when out in the community. "Recovery image" relates to the adolescent's behaviors and attitudes in the home, school, and community environments. Relapse prevention skills may be reviewed, often in the context of developing a continuing care plan. A continuing care plan identifies how the adolescent is going to maintain sobriety and pursue a non-using lifestyle after leaving treatment.

Individual Session Topics and Themes

As noted above, the content or type of individual sessions will vary based on individual needs and the stage of treatment. It should also be noted that the following topics are sometimes addressed in the context of groups, either skills groups or counseling groups. They may then be followed up in individual sessions. Some of the more common agendas include:

- Admission (typically a family session)
- Developing goals for the MTP
- Reviewing progress or lack of progress on MTP goals
- Continued assessment for diagnostic changes
- Addressing personal issues such as lack of social skills, abuse, parental divorce, or asking about medication side effects
- Discussing urine screen results
- Discussing specific goals that need to be accomplished in order to be transferred to a less intensive level of care or to be successfully discharged
- Completing a specific goal such as making a poster about anger management issues or completing a drug and alcohol history
- Discussing behavioral problems occurring in groups or in the home environment
- Identifying the positive changes of the adolescent and encouraging them to continue in the recovery process

Descriptions of Different Types of Individual Sessions

While it would be difficult to provide an example of every possible type of individual session, the sections that follow provide examples of the most common types of sessions. Each section describes the purpose for the session and then is followed by one or more sample dialogues between a counselor and adolescent to further illustrate what occurs during this type of session.

Admission Sessions

Admission sessions are scheduled as quickly as possible following the adolescent's assessment and recommendation for treatment. The guardian(s) are told that they are required to participate in the admission appointment. This increases the number of parents who attend the

admission process. CHS believes it is critical for parents to attend this initial session so that they will become involved in the treatment process. If the adolescent shows up for the admission by him or herself, the counselor does not have the opportunity to answer questions about guardian signatures or admission paperwork and has to copy the forms and send them to the guardian for approximately 10 signatures.

The counselor begins the admission process by explaining what the process involves: answering any questions, completing paperwork, and identifying treatment goals for both the adolescent and family. Of course, the adolescent's and/or family's level of resistance is a key factor in the counselor's approach to involving the family and adolescent in treatment and goal setting. It is important for the counselor to place the responsibility for participating in treatment on the adolescent and family. At the same time, the counselor needs to present him or herself as a willing partner in helping the adolescent and family deal with substance abuse issues.

As the admission paperwork is reviewed and signed, questions sometimes arise. The counselor should always answer questions as they are raised. Taking the time to thoroughly answer any questions helps build an open and honest relationship. In fact, the counselor may be able to formulate goals from the adolescent's and family's questions. For example, if the adolescent is resistant to signing a disclosure authorization to his or her probation officer, the counselor can explain that staying in weekly contact with the probation officer will help make a treatment episode shorter. The counselor needs to help the adolescent and family understand that treatment is a collaborative process that involves others who have been affected by the adolescent's behaviors. It is imperative that the counselor presents this as a supportive intervention, and that the goal is to help the adolescent in all areas of his or her life.

One goal of the admission session is to help the adolescent and family understand that change is possible. The counselor communicates with the family in a non-judgmental way and tells them that they do not have to blame themselves for their adolescent's problems. The counselor also communicates that excessive parental control will not necessarily lead to an adolescent's abstinence. Another goal of this session is to review consequences of continued use. During this discussion, the counselor models for parents how to detach and avoid arguments and notes that the responsibility for changing or not changing lies within the adolescent. This discussion may lead to the development of goals for parents to work on, both for their sanity and the good of the adolescent. The adolescent can be enlisted to help articulate

goals for the parents that would better their relationship. Goals might include less arguing and fighting, changes in house rules, or allowing the adolescent to have his or her own phone line. The family can discuss where compromise is possible and also the rules/expectations that will not be altered. For example, using illegal substances in the guardian's home would not be a negotiable issue. Negative consequences for continued substance use and positive consequences for abstinence are clarified. The counselor describes how the adolescent's requests (e.g., a later curfew) are related to earning trust. The adolescent may be asked to describe ways he or she could increase trust and thus get what he or she wants. Helping the adolescent see that trust building is a process, and that trust is earned through multiple behaviors, may lead the family to define goals in terms of several steps. This increases the chance that an adolescent will be successful and that the family will be aware of positive, small changes in the adolescent's behaviors.

Since the admission session almost always includes a parent/guardian, it is an ideal time to discuss both the adolescent's and family's perceptions about problem areas and desired changes. Differences in opinion between the adolescent and family regarding problems can often be reconciled by reframing a negative behavior in a positive way. For example, the family member may identify disrespectful behavior as a problem. An adolescent might counter-argue that he or she is disrespectful because the family member is "always hollering at me and never says I do any good." A MTP goal might state that the family would compliment the adolescent at least twice a day and write out the compliments. Progress toward this goal could be reviewed at a later family session. An additional goal might direct the adolescent to identify people he or she respects and how respect is demonstrated. Then, at a later family session, the adolescent's ideas could be shared and discussed. Related goals might include learning about and practicing assertiveness and/or attending groups on anger management.

Developing Master Treatment Plans

After the admission session, the next individual session is usually conducted to develop the MTP. While many specific MTP goals are appropriate for the majority of adolescents, the MTP also includes goals unique to each adolescent. Individualizing MTPs is accomplished by reviewing the adolescent's and collaterals' assessment information (i.e., GAIN-I, assessment summary report, and the Collateral Assessment Form) and taking into account information

provided by other sources (e.g., a probation officer). Once developed, MTPs are reviewed with OP adolescents at least once every 30 days and with IOP adolescents at least once every 14 days.

Treatment Progress Review Sessions

MTP reviews, or Continuing Stay Reviews, are the most common reason for conducting individual sessions. These sessions are structured and often directive. The counselor typically reviews and writes on the MTP the adolescent's progress and difficulties since the last review. The goals/objectives in each ASAM dimension are read to the adolescent. The counselor may ask for feedback from the adolescent regarding progress on the goal, or the counselor may read or paraphrase what he or she wrote concerning the respective goal. The counselor is expected to help adolescents recognize how they are moving in a positive direction by working on their goals. For example, a relatively straightforward goal is to attend groups and earn appropriate scores. (Note: Adolescents earn a score in each group based on their level of participation and behavior. Scores range from one to four with scores of three and four being "appropriate scores.") The counselor may emphasize the adolescent's commitment (i.e., being responsible) and how this is a positive change in the adolescent's lifestyle. MTP review sessions generally end with a review by the counselor of the goals that the adolescent can work on in the coming weeks. The adolescent and counselor then sign and date the Continuing Stay Review.

When reviewing goals, the counselor may find it important to break down a goal into smaller steps in order to "set the adolescent up" for success. The following is an excerpt from a session during which the counselor is discussing with the adolescent his goal to change his reputation.

Counselor: *So your goal is to change your reputation. How are you going to do that?*

Adolescent: *Monitor my thoughts and actions. And change them until the right one happens.*

Counselor: *How are you going to do that? I mean that sounds great!*

Adolescent: *Concentrate.*

Counselor: *How do you do that?*

Adolescent: *I don't know. That is hard to do.*

Counselor: *It is a pretty big order if you don't break it down into small pieces. The monitoring of thoughts will almost always reveal things.*

Adolescent: *Yeah.*

Counselor: *"Where did that thought come from?" We all need to do that. We can listen to our self talk. You are intelligent. You can do that, you can do that. So you are going to start monitoring how you think. Are you going to monitor how you feel?*

Adolescent: *You mean physically or emotionally?*

Counselor: *Emotionally.*

Adolescent: *It is hard. I can't.*

Counselor: *Well, let me give you one example of how to do this. When you get discouraged, like when your parent's issues start bugging you, you have certain feelings come up. And you handle them. I know you have monitored your feelings in that situation. You know you can wear a rubber band and every time that a negative feeling or unpleasant thought occurs, you can snap it. Or you can count backward in increments of ten. That can help change the topics in your head or your feelings. But sometimes you have to live through that feeling… not stop them, but actually say, "It's okay, it is okay to feel discouraged. It is okay to feel disappointed." It might not be pleasant, but it is all right. It is good that you start monitoring thoughts. You can let your feelings out a little more. Let's see, right now I am feeling. . . How am I feeling? Sometimes you manage to avoid knowing how you are feeling. Just check in with yourself. I would imagine that for a while that will be hard.*

Adolescent: *I have been trying to do that.*

Counselor: *Have you really? How did you feel this morning?*

Adolescent: *Really, really, really tired.*

Counselor: *Tired and what?*

Adolescent: *Just lousy. No energy.*

Counselor: *How did you feel when you found out you were going to be late to outpatient groups?*

Adolescent: *I was kind of mad because I thought I would just jump in the car and get here in time. Which I almost did, but I was still really tired. I was kind of relieved, too.*

Counselor: *Wow, that is a bunch of stuff… mad, frustrated…*

Adolescent: *Yeah, almost left out, like, oh crud, I missed something I was supposed to do. Or whatever that feeling is when you forget something you are responsible for. Guilt.*

The following examples also review progress on specific MTP goals. The first dialogue illustrates the MTP goals of attending school on time and learning how to avoid boredom.

Counselor: *Sounds like you are doing pretty good with school.*

Adolescent: *Yeah.*

Counselor: *What are you doing different this year?*

Adolescent: *Doing all the work.*

Counselor: *You do homework too?*

Adolescent: *Yeah. I actually pay attention in class.*

Counselor: *What came over you?! Something changed in you.*

Adolescent: *Quitting* [using cannabis].

Counselor: *Yeah, sometimes that is a part of it. You can focus better and remember better. You've talked about that before* [school problems directly related to smoking cannabis].

Adolescent: *Since I quit using, I have more time to do it* [school work]. *It's so hard.*

Counselor: *School or quitting using?*

Adolescent: *School.*

Counselor: *Yes. You are a sophomore. Well that is a big change from last year. You know when your mom and dad came in for a family session, school was one of their biggest worries. So you are making them happy. That is worth something. Plus, you are helping yourself. What else did you work on last week? Do you think about working on goals as you go through the week?*

Adolescent: *Yeah, I try to.*

Counselor: *Great! Like what?*

Adolescent: *Just going to school.*

Counselor: *Yes! I agree. That is a good goal. And…you are doing well with not using. It has been about two or three weeks since you used, right?*

Adolescent: *Yeah.*

Counselor: *You are making good progress on your treatment goals. I knew you could do it. You have talked about being easily bored. Have you been able to work on being less bored?*

Adolescent: *I don't do anything.*

Counselor: *That sounds boring! Well, when people stop using, that can be a big problem. You have to figure out how to party without using. How can you have fun without using? Or you are going to get bored.*

Adolescent: *I go places.*

Counselor: *Like where? Movies, shopping, out to eat, work?*

Adolescent: *Yeah.*

Counselor: *All of those things? You go to movies?*

Adolescent: *Yeah.*

The next dialogue example concerns progress made on the MTP goal of obtaining part-time employment. The adolescent had agreed to begin working on this goal in a previous counseling session the week before.

Counselor: *You have done really well with accomplishing your school goals. A goal we talked about last week that you said you would begin working on had to do with getting a job. How did it go with that?*

Adolescent: *I am really deciding where I am going to work at. It is either McDonald's or Wendy's. I know that. But at Target, I can work more hours for better pay.*

Counselor: *So you have made a decision…you are going to get a job. Have you set a date?*

Adolescent: *I have to have it before October something.*

Counselor: *For a school requirement?*

Adolescent: *Yeah. Or I will get kicked out.*

Counselor: *Well that is a good reason to get a job. I know school is important to you. Well let's see. You said last week that you were going to check on an application. Were you able to do that?*

Adolescent: *Yeah, I got one.*

Counselor: *Great! So you did what you said. Have you filled it out yet?*

Adolescent: *Half of it.*

Counselor: *So you started on that goal. And can you get to Wendy's this week to pick up an application?*

Adolescent: *Yeah, I can.*

Counselor: *So when we meet next week, you will have completed applications for both McDonald's and Wendy's?*

Adolescent: *Yeah, I need to do that.*

Reviewing Urine Screen Results

Leaving clean urine screens is a treatment goal for all adolescents. Adolescents in IOP generally leave screens every week. OP adolescents are asked to leave screens about every two weeks. Urine screen results include several pieces of information besides the presence of any of seven commonly abused substances. A level (quantity) is indicated for each drug of abuse. Thus, a screen may be positive, but the level may have decreased (or increased) significantly from the last screen. Second, the creatinine level is indicated. A low creatinine level (the cut-off level is determined by the laboratory that runs the tests) strongly suggests that the urine was tampered with in some way. Attempts to alter urine screen results are common.

Counselors try to discuss urine screen results with an adolescent as soon as the results are available, which is generally around six or seven days after the screen is provided. Counselors may spend ten minutes discussing the results either before groups or between groups. If the results are positive, the adolescent is encouraged to talk about it in a skills or counseling group. While it would seem that the concrete nature and clarity of a positive urine screen result should

minimize lying about recent use, this is very often not the case. When an adolescent denies use, the counselor is expected to listen, state that it is difficult to admit to relapse, and then repeat the fact that the urine screen is positive. It is helpful to have a copy of the urine screen results so that both the counselor and adolescent have a copy in their hands. Very often the adolescent moves from complete denial, to "being around it" (i.e., at parties, in a car with users), to using "only once," to the actual truth. The counselor facilitates this process by bringing the adolescent back to the printed urine screen results. It is not helpful for the counselor to become frustrated or to accuse the adolescent of lying. Calmly presenting the results, over and over, nearly always leads to admission of substance use. Since honesty is a critical key to maintaining sobriety, it is also therapeutic to discuss the difficulty that the adolescent had in being honest and what kept him or her from being honest in the first place.

Skills Training Sessions

Individual counseling can be used to help an adolescent better understand, develop, and practice various skills. Social skills like personal hygiene, assertiveness, listening, and communicating honestly all can be addressed in individual sessions. Adolescents are frequently unaware of how their behaviors negatively impact others. Many tend to blame others and not consider any of their actions as part of the problem. The counselor attempts to convince adolescents that they will have desirable outcomes if they change: that is, better friendships, less arguing, increased trust, or no more treatment. Since most adolescents also attend groups, this is an opportune time for the counselor to help the adolescent see the relevance of skills groups topics.

Relapse prevention is a skill that is frequently addressed in skills groups, individual counseling, and family counseling. In fact, relapse prevention involves many skills. Skills that are helpful in maintaining sobriety include assertiveness, utilizing social supports, developing new non-using friendships, avoiding boredom, and maintaining a structured schedule. The following excerpt is from an individual session with an adolescent whose treatment involved only individual counseling. Relapse prevention and making life changes are addressed.

Counselor: *How many people do you know that don't use?*

Adolescent: *Probably five.*

Counselor: *Five friends that you have.*

Adolescent: *Yeah, but on a weekly basis, I probably hang out with eleven of them.*

Counselor: *Uh huh.*

Adolescent: *So, almost half of my friends that I hang out with don't use.*

Counselor: *Uh huh.*

Adolescent: *So I don't really find myself in situations where I'm just with one person anyway.*

Counselor: *Mike, hearing you say that it is easy to avoid situations where friends are using, is something I don't hear very often. When I am doing groups, most kids say you can't avoid it. It is everywhere they go; they run into it. And now you are saying that it is easy to avoid!*

Adolescent: *I think that most people are looking for it still.*

Counselor: *Okay.*

Adolescent: *Because, like well, in the first month it was everywhere I went but mainly because I went to where it was.*

Counselor: *Uh huh.*

Adolescent: *And most people are probably still hanging out with the same people or same places.*

Counselor: *Uh huh. What kind of changes have you made?*

Adolescent: *I just don't go to a couple of houses. I don't go to Tom's house anymore. That is mainly where it happened* [using]. *Lately I go to a friend's house where we like just jam out* [adolescent is a musician] *and pretty much none of them like, use. I run into it every now and then out there, but the ones that do use go sit out in their car or go listen to music. Usually, I am downstairs playing or watching TV or outside smoking cigarettes. I still haven't given up on cigarettes. Right now that feels hard to stop.*

Counselor: *Yeah. That would be a tough one.*

Adolescent: *The cigarettes are weird, too. I know that if I keep smoking there is a big risk of getting cancer, but I don't care.*

Counselor: *Yeah.*

Adolescent: *Like I care but not enough to stop. Here is what I have been thinking about doing. Trying to cut back, anyway.*

Counselor: *Uh huh.*

Adolescent: *And slowly, gradually going down…space them out over the day. And once I figure I get down to three cigarettes a day, I can stop.*

Counselor: *So what is it with all of these changes? I mean you have already quit using drugs. You have been working on changing your sleep patterns, which I think is a very good thing, and now you want to cut down on your cigarette smoking. What is up with this?*

Adolescent: *I don't know. Just been thinking, I guess. I guess I just want to change some things. I don't want to be some bum on the side of the road. You know, I don't want to be working at McDonald's or be a bag boy or sitting in my chair carrying around some big oxygen tank or something. Because I see people like that.*

Counselor: *Yeah, yeah.*

Adolescent: *There are just some things that I don't want to have happen, so I figure I will just start knocking them off one by one.*

Counselor: *Good for you!*

Adolescent: *There are some things I don't know if I will be able to knock off, though.*

Counselor: *Well, you know what, all you can do is try.*

Adolescent: *The cigarettes I have to try, though.*

Counselor: *Yeah. That will be a tough one. But you know, you can do it.*

It is common for adolescents to initially have a goal of decreasing their substance use, both the number of days and quantity. All adolescents are eventually encouraged to maintain total abstinence while in treatment and afterward. In the following example, the counselor is supportive of the adolescent's decrease in substance use. The counselor encourages the adolescent to continue engaging in the behaviors that have helped him cut down in the past. Personal relapse prevention skills are reviewed with the adolescent.

Counselor: *A tough goal you have been working on is not using. And in the beginning your goal was to cut down. And I think you did! Last week you said you used once. How did you do over this past weekend?*

Adolescent: *The only time I used this weekend was yesterday.*

Counselor: *What was going on yesterday?*

Adolescent: *I hung out with my best friend. Smoking* [cannabis] *gave me a terrible headache.*

Counselor: *Oh, did it? Smoking weed. Well, that would be a good reason to stop. What could you have done differently to not use?*

Adolescent: *I should have said no. I could have refused.*

Counselor: *Yeah. The very first thing you could have said was, sorry, I've got to stay at home. Did you kind of have an idea in the back of your head that if you went to his house,…*

Adolescent: *Yeah, I knew.*

Counselor: *I see that smile.*

Adolescent: *I knew. Every time we get together, I already know whether we are going to smoke.*

Counselor: *Yeah, it is hard to say no. It is hard. The times you were able to say no, what helped you to say no? Do you remember those times?*

Adolescent: *I guess I hardly say no. My mom said no for me once. I don't use at my mother's house.*

Counselor: *Well then, let me ask this. What if your friend comes over to your house tonight? It sounds like you have to make a decision when a friend comes to the door. Say yes or no when he asks you to go with him.*

Adolescent: *I can say no. My mom will help me.*

Counselor: *Yes, your mother will help you if you ask for help.*

In the next example, the counselor tries to help the adolescent focus on how confident he or she is that he or she can quit substance use. This is another example of helping an adolescent to develop personal relapse prevention strategies. The adolescent had been talking about going

to college. At the time of the session he is in the 9th grade and on the baseball team. He had been in treatment about a month and was working on maintaining total abstinence. At this point, he had significantly reduced his level of using.

Counselor: *You know when you are on any athletic team in college, they do drug screens. And that is another good reason to stop now. How much do you believe that you can stop using?*

Adolescent: *I know I can stop.*

Counselor: *Well I know you can stop, too. But just say that if 10 is 100% sure you can stop in the next month, and 1 is there is no way you can stop in the next month, what would you rate yourself?*

Adolescent: *Seven.*

Counselor: *So you are pretty sure you can stop within the next month. That is good!*

Adolescent: *Well I know I can. I'd say a 10 because I know I can.*

Counselor: *Really?*

Adolescent: *I just got to try.*

Counselor: *You started with 7 and then you said 10. What is the most important thing you need to do to make sure it is a 10—that you stop in the next few weeks?*

Adolescent: *Socialize with other people who don't use.*

Counselor: *Excellent! And does that include not socializing with your old using friends?*

Adolescent: *I think I can still talk to them.*

Counselor: *Uh huh.*

Adolescent: *If I am not smoking and they are not smoking.*

Counselor: *Well that is a possibility. Is that your experience?*

Adolescent: *Yeah. Pretty much. Because we all like to do the same things. It is like a chain reaction.*

Counselor: *Uh huh. That is a good observation. When one person does something it kind of gets the other person to want to do it. It might take avoiding your old using friends. You know when one person plays basketball, his friends will probably play basketball. But if one person stops using, the others don't necessarily stop. It is hard to stop. Think about that. But that's great if you stop. Because you can be a role model to your friends. You could work on that this week. You said you can stop and I believe you can stop.*

Identifying Adolescent Strengths

Identifying the adolescent's strengths during the early stage of treatment is helpful in building the therapeutic relationship. The counselor seeks to uncover any overlooked or hidden talents, especially in cases where it appears that parents and teachers have been primarily focused on the adolescent's negative behaviors. It is also possible to re-frame and re-direct behaviors that had previously been viewed as negative. For examples, the counselor might praise leadership skills, skateboarding or other sports, musical abilities, or honesty with parents about using. Other strengths that a counselor might identify are sensitivity to others' feelings, having a lot of energy, creativity, open-mindedness, tolerance, concern for others' physical well-being, or being good at a particular school subject. Building a cooperative working relationship is not possible if the adolescent feels that the focus is always on his or her "bad" behavior. The counselor is expected to provide support and direction, not ultimatums. The counselor does not want to portray him or herself as another authority figure bent on taking away more freedoms.

The following excerpt is from an early treatment session. The adolescent is able to recognize the positive consequences of not using (e.g., not being controlled/"in love" with cannabis, doing better in school) and he believes he can stop smoking cannabis.

Adolescent: *It is pretty much impossible to get away from it* [cannabis]. *I see it every day. I hear about it every day.*

Counselor: *Yeah, that makes it really hard.*

Adolescent: *I just… don't use. I sit back and don't do anything. I got off of it at least.*

Counselor: *That's really good. Earlier you said that you don't need to smoke* [cannabis] *anymore.*

Adolescent: *Well I have been away from it so much. I'm not going back.* [The adolescent has actually only two to three weeks of sobriety.]

Counselor: *Yes. Well I know you can do it. But it is hard. You said that you don't need to. Why did you need to before?*

Adolescent: *Because I loved getting high.*

Counselor: *Don't you still love getting high?*

Adolescent: *Not as much. If I sneak back to using, I might get caught.*

Counselor: *Okay. So your love is decreasing for weed.*

Adolescent: *Basically.*

Counselor: *Uh huh. That is funny because I do a group that talks about saying good-bye to weed and grieving for the loss. I think people can fall in love with drugs. I really do. Not the same as for a woman or a man, but you fall in love with it. It does a lot of good things for you, and a lot of bad things, too.*

Adolescent: *So what's the problem with that—it does good things?*

Counselor: *What is the problem with that? Well, do you like coming here three days a week?*

Adolescent: *Oh. I don't do it because it is against the law.*

Counselor: *Yeah. And you said yourself that your school performance suffered directly because of smoking weed. Does doing better in school and not smoking weed get your parents off your back a little more?*

Adolescent: *Yeah.*

Psychiatric Follow-up

Counselors are expected to monitor for the emergence of psychiatric symptoms. When they are initially assessed, many adolescents endorse symptoms of depression, ADHD, and/or conduct disorder. Symptoms of PTSD, anxiety disorders, and sleep disorders are also endorsed, but to a lesser degree. While in some cases, symptoms are related to the effects of substance abuse and remit once an adolescent stops using, a significant number of adolescents have co-occurring psychiatric disorders. Individual sessions are opportune times to re-assess the need to

rule in or rule out preliminary suspected diagnoses. Counselors are strongly encouraged to be very direct in assessing suicidal and homicidal ideation. Also, counselors are trained to review the DSM-IV criteria for the disorder(s) in question with the adolescent.

The following excerpt involves an adolescent who had been assessed by the CHS psychiatrist. The adolescent was unable to maintain abstinence for more than four or five days at a time and was scheduled to be transferred to residential treatment.

Counselor: *What would make you the happiest if you could change one thing about your life?*

Adolescent: *Everything.*

Counselor: *Wow! Everything? We already talked about how you are usually caring, kind, a good baseball player, and you are more honest. Would you change that?*

Adolescent: *I wish I could live in a different place. I wish I could know different people. I wish I was a different way.*

Counselor: *What way?*

Adolescent: *Just how I act. Just different. I don't like it. I get in moods sometimes and I get really mad sometimes. Like I can be happy at one point and one thing happens and I just can't get back* [to being happy]. *These could be little things. Flips my whole day around.*

Counselor: *So if your mood was more smooth—not real angry, not real sad. Things like that?*

Adolescent: *Yeah.*

Counselor: *Remember when you saw Dr. C.* [CHS psychiatrist]*?*

Adolescent: *Uh huh.*

Counselor: *He saw those things* [mood instability]. *And he saw that you had a problem with it. He thought he could help you, but he said that you needed to stop using because he wasn't one hundred percent sure if it was related to using. Mood problems are sometimes caused by using, and sometimes they are not. And if a person is depressed, using can make the depression worse. So as soon as you stop using you can see him again. He will probably be able to help you. There are a lot of medications that are real safe. You might feel a lot better. The medications keep you from*

getting so angry and keep you from feeling so depressed. And they usually help with sleeping. They are not addictive at all. There are some side effects, but nothing too serious. It seems like you could work on that problem as soon as you stop using. And you have a good start on that goal.

Adolescent: *Yeah. That would help.*

Family Issues

Most, if not all, adolescent clients have family issues that can affect their recovery process. The issues range from parental concern about the adolescent's substance use and behavioral issues to parental or sibling use in the home. Parents are often frustrated and angry. They have been dealing with the adolescent's behavioral and emotional instability, sometimes for years. Our experience has been that adolescents often display anger and blaming behavior towards their parents. It is critical that the counselor listen with unconditional positive regard while the adolescent expresses these feelings, so that there will be an opportunity for understanding why the adolescent feels the way he or she does. The counselor can then "walk in the adolescent's shoes." Building a therapeutic alliance is the first step in helping adolescents understand their role in family problems and what they might achieve/gain if they try to make family-related changes. Adolescent gains might be couched in terms of getting their parents off their back or the relaxing of certain house rules (e.g., curfew, driving privileges, time on the telephone). At other times, as the following exchange demonstrates, simply listening with empathy as an adolescent discusses family relationships can be a therapeutic intervention. Immediately prior to the following exchange, the adolescent talked about how his mother was strong and brave and was a positive role model for him.

Counselor: *Maybe you got some of your bravery from your mom?*

Adolescent: *I sure didn't get it from my dad. He is a coward. I don't like him.*

Counselor: *When was the last time you talked to him?*

Adolescent: *Three months ago—sometime during the summer.*

Counselor: *Where does he live?*

Adolescent: *In Bloomington. He doesn't ever come to see me. He expects me to go see him.*

Counselor: *Pretty angry at him?*

Adolescent: *Yeah. He was in prison until I was like eight or nine. When he got out, he never came to see me or take me shopping. I never got anything for my birthday. He never paid child support.*

Counselor: *I can understand why you are angry and said that he is a coward… Do you think about him much?*

Adolescent: *Not really.*

Counselor: *Kind of used to living without him?*

Adolescent: *Yeah.*

Counselor: *Is that hard, living without a father?*

Adolescent: *No, other people get along. They have somebody to look up to.*

Counselor: *Like a dad should be?*

Adolescent: *Yeah. My Uncle Sam is good.*

Counselor: *Pretty good man?*

Adolescent: *Yeah. And my cousin. I look up to him. He doesn't use either. They are like my role models. Instead of my dad.*

The next dialogue example also addresses family issues as well as relapse prevention. This was a middle session. The adolescent had relapsed two weeks prior to the following interaction.

Counselor: *How long have you been clean now?*

Adolescent: *Okay. Let's see… I bet you have counted. Two weeks? Two weeks today.*

Counselor: *So, how has it been for you those two weeks? Is the craving as bad as it was last week?*

Adolescent: *Not really. Like I don't know. It is just that like I want, I would want to get high or whatever but I don't feel like it. Like there is no motivation to it.*

Counselor: *So you are saying that your need is less? Your need to get high is a little less than it was?*

Adolescent: *Yes.*

Counselor: *Have you been away from it long enough to see that you really can do without it?*

Adolescent: *Yeah. I know that I can be without it.*

Counselor: *Well you have gone fourteen days so you can go one more day. And then one more day and then one more day. I think it is more doable when you think about staying clean just for today.*

Adolescent: *It is hard to concentrate on one day though for me.*

Counselor: *Okay. Is it easier for you to just make a blanket transition?*

Adolescent: *Yeah. Just to say, don't do it. Don't do it at all.*

Counselor: *Okay. See, some people really can't handle that. They have to keep telling themselves "this day." But whatever works for you. What was the AA meeting like for you last night?*

Adolescent: *I don't like AA, period, for my own reasons. All of the people were really… I don't know, just had like really bad attitudes. Which I can see, like, being an alcoholic and not being able to drink.*

Counselor: *Were there new people? I mean could you tell that they hadn't been sober for very long?*

Adolescent: *Yeah. A lot of them said they had been sober for just a while.*

Counselor: *How long?*

Adolescent: *Um, not very long.*

Counselor: *So maybe they were struggling? You said that you didn't like AA for your own reasons. What are your main reasons?*

Adolescent: *Because of my mom.*

Counselor: *Your mom is recovering? You had never mentioned that to me.*

Adolescent: *She is not recovering.*

Counselor: *Okay.*

Adolescent: *She has never drank. Never. She like did it once or maybe on two days—because my dad was out of town.*

Counselor: *Go ahead. I'm confused. Are you saying she is not an alcoholic or she is not in recovery?*

Adolescent: *She is not an alcoholic.*

Counselor: *So how often does she go to AA meetings?*

Adolescent: *Like all the time. She likes the people she meets there. I can't understand. She says, "well, I'm an alcoholic," and she is not.*

Homework Goals

The counselor works to help the adolescent understand that treatment goals are life goals. And equally important, the counselor helps the adolescent understand that one's behavior can be determined by one's goals. "Setting the adolescent up" for successful goal completion with realistic and attainable goals is the counselor's responsibility. Accomplishing goals increases adolescent self-esteem and confidence. The counselor typically asks the adolescent about his or her progress on homework goals at each session. These questions provide an opportunity to demonstrate concern and interest in the adolescent's life as well as reinforce goal accomplishments.

The following dialogue is taken from the last few minutes of an individual session. The adolescent had been in IOP for about a month. He was to be transferred to OP the following week, if he left another clean urine screen. This session could be considered as a late initial session or an early middle session.

Adolescent: *Are we done? I'm hungry.* [CHS has snacks between groups, which would be after the counseling session].

Counselor: *You're right. It's about that time. Anything else you want to talk about?*

Adolescent: *No.*

Counselor: *Hold on just for one more second. Let's go over what you are going to work on in the coming week. Another clean screen—no using. Going to school and doing your homework, which you have been doing very well on. Keeping your part-time job—not missing work. What about related to your family? What can you work on in that area? Can you sit down and talk with them at least once? How about talking with them and letting them know that it seems to you that they don't appreciate you leaving clean screens. That they don't appreciate it as much as you would like.* [Earlier in the session the adolescent talked about feeling this way].

Adolescent: *Yeah, I guess. I'll try.*

Counselor: *In the next week?*

Adolescent: *Yeah.*

Counselor: *Great! Okay. Let's stop here.*

Treatment Progress Review—Preparing for Discharge

When adolescents have demonstrated a commitment to recovery and have consistently worked on completing their MTP objectives, a specific discharge date is discussed. Discussing discharge often functions as a motivator for adolescents to maintain their positive attitude and continue working on their MTP objectives. The adolescent is encouraged to be a positive role model for other adolescents. The counselor may ask the adolescent to "co-lead" a group or groups. Recognizing the adolescent as a leader is generally a strong reinforcer for continued positive behavior.

Work may begin on the adolescent's continuing care plan. The plan addresses all facets of a recovery lifestyle including expected school performance, following through with legal obligations, family and peer support, AA/NA involvement, and any needed referrals to a medical doctor, psychiatrist, school counselor, family counselor, or an individual counselor. When the adolescent is discharged, the continuing care plan is reviewed with the family. The following interchange is taken from a session occurring near the end of an adolescent's OP experience. This particular adolescent is to be transferred to residential treatment due to continued substance use and behavioral and emotional instability.

Counselor: *Is there anything else you would like to talk about?*

Adolescent: *No.*

Counselor: *I'll see you next Friday, okay? Please have your mom call me. I'm not having any luck reaching her by phone. And the plan is for you to go to residential treatment, probably in two to three weeks.*

Adolescent: *How long would I be there?*

Counselor: *Well, it is hard to say. Treatment lengths are not set in stone. This is what I can tell you. People in your situation—going from outpatient to residential—are usually in treatment from 40 to 90 days.*

Adolescent: *That is like two to three months?*

Counselor: *Yes. If you do okay, do what you need to do, there is really no reason why you couldn't be out of there in about 40 days. If you don't use, you go to groups, you talk. And you are a good talker. You are smart. You'll get it okay.*

Adolescent: *What kind of groups?*

Counselor: *Oh, they have lots of groups like ours. On relapse prevention…on emotions…on your mood…on getting along with your family…on finding friends that don't use…on anger management—how to deal with anger. We just don't want you to get into any more trouble. Things like that. So they do a lot of the things we do, just more of it. Plus, it is harder for you to use while you are in residential. You go on passes. You have to earn passes, but it is not hard. You can leave on a pass about every weekend. At the beginning, passes are around four or six hours, and by the end of treatment you go for 24 hours.*

Adolescent: *Where?*

Counselor: *Wherever you want, with your mother. So I think residential will really help you. Remember, the lower your screen level* [THC]*, the better. You will be showing them that you already started to stop using. So that would be a really important goal to work on this week: not using at all. I know you can do it. You can't spend time with certain people. That would really help you accomplish this goal. Any other questions?*

Adolescent: *No.*

Counselor: *Okay. Let's stop here then.*

Discharge Session

Final individual sessions also must address the issue of termination; that the counselor/adolescent relationship is coming to an end. The counselor typically acknowledges the adolescent's strengths and the positive changes that were made while in treatment. The adolescent is empowered by expressing confidence and support in his or her ability to maintain a recovery lifestyle. It is also important for the counselor to strongly emphasize the need to follow through with all referrals, particularly psychiatric follow-up for medication management. The final focus should be on the adolescent's successes, not the difficulties they experienced while in treatment. The following dialogue occurred in an individual session on the day that the adolescent was successfully discharged. Although his parent (mother) was invited to the session, she did not attend.

Counselor: *I wish your mom could have made it. You worked hard for this day. Have you talked with your mom about any changes she has seen in you?*

Adolescent: *Yeah. I think she is proud of me. We argue a lot less. I spend more time at home and I actually don't mind. My mom is nicer. I do my jobs* [chores] *around the house and she likes that. She bought me a couple CDs because I keep my room clean.*

Counselor: *You have made many positive changes! Very good. How do you feel about your new relationship with your mom?*

Adolescent: *I feel… happier, better. I used to really disrespect her. I don't want to do that anymore. Not using is a big part of that. I didn't care, but now I care.*

Counselor: *Yeah. I can see you care, especially in the last few months. You are a strong leader in groups. The others* [adolescents] *listen to you. And you confronted them when they broke rules and acted stupid, and when they started getting into war stories. They know you are serious about recovery. I believe you gave others hope, that they could stop using too and still have fun. You showed them that recovery is a lot of work, but worth it. Have you changed in other ways while you were in treatment?*

Adolescent: *Well I haven't used in about four or five months. Before this, I don't think I ever went for more then two or three days without smoking or drinking. And that was for a long time. I started caring more about my consequences, especially legal. I was losing more and more freedom. So not using is real important—I don't have to worry about going to jail.*

Counselor: *Not using for five months is a major accomplishment. You ought to be proud. You know, only about half the adolescents ever make it to this day. I'm proud of you sticking with it and really working on your treatment goals. I think another accomplishment is your honesty.*

Adolescent: *Oh, yeah. I used to lie all the time, to everybody—my mom, my friends, teachers. I know the lying was because of the using. It's easier—just everything—when I don't have to lie. I sorta liked to see if I could fool others—make them believe my lie. But it kind of bothered me too. I got a reputation for being able to con others—basically being a good liar. As I stopped using, I didn't like that reputation.*

Counselor: *I'm really glad that you feel it is better to be honest with others. I know I appreciate your honesty. Isn't school going better now?*

Adolescent: *Lots better. I go every day. My grades are a lot better. It's like that other stuff—now I care more about things, like getting my diploma.*

Counselor: *Yeah. Drugs are really powerful. They affect everything. Are you confident that you can continue to stay off weed and alcohol?*

Adolescent: *Definitely. I'm going to keep going to a couple of NA meetings a week. I know I can't party with my old friends. I'll use. I got a job, so that helps me stay busy a couple nights a week and on Saturday. I'm gonna see my probation officer every week for awhile. I have to leave [urine] screens at probation. That helps. My mom is real supportive. I'll probably watch some videos with her. We both like to do that. I know I need to keep myself busy. I get bored pretty easy and then I start thinking about smoking.*

Counselor: *You really have learned a lot about yourself. You have some real positive goals to help you stay clean. And you know you can always call me. If you don't get me, leave a message—I'll call you back. I've really enjoyed watching you change. I know it was hard. It gets easier as time goes on. Probably the hardest part is the next two or three months. So don't be afraid to ask for help. Lots of people want to help you. Lots of people care about you.*

Adolescent: *Yeah, I know. Okay.*

VI. Skills Groups Work with the Adolescent

Skills groups are the primary mode of treatment delivery for adolescents at Chestnut. While approximately 15% of adolescents participate in only individual and family counseling, most adolescents attend skills groups and group counseling. Detailed instructions for conducting each skill group can be found in Appendix C. Although summer scheduling may vary, typically groups are scheduled from 4 p.m. to 7 p.m. on Mondays, Tuesdays, and Thursdays. Wednesday groups are scheduled from 4 p.m. to 6:15 p.m. On Mondays and Tuesdays, two groups are sometimes scheduled simultaneously in order to allow for the separation of OP adolescents and IOP adolescents, or if there is a relatively high number of adolescents that night. When appropriate, groups are also held for two hours weekday mornings. These groups are offered for those adolescents who are unable to attend the evening groups due to their involvement in alternative education classes during this time.

Skills groups are by definition educational and facilitate learning new skills and behaviors. They provide opportunities for adolescents to teach one another and practice interacting and behaving appropriately in a classroom-type setting. Chestnut clinical staff members believe, however, that change is encouraged through the use of techniques that are often associated with counseling groups rather than a solely didactic approach. Therefore, it is common for skill group session discussions to evolve into ones similar to those found in counseling groups. For example, the leader and other group members might use empathic listening while an adolescent speaks about his or her feelings. Counselors are expected to be flexible leaders so that adolescents are encouraged to relate to the skill topics on a personal level. Whenever an adolescent is willing to relate on a personal level, this is viewed as an opportunity for a learning/therapeutic experience. The counseling atmosphere may last for only a few minutes, with the leader helping to keep the discussion on task, and then the group will be redirected back to the group exercise. The overarching goal for a skills group leader is to provide a non-threatening atmosphere and help adolescents explore positive alternative behaviors.

Format of Skills Groups

All groups are 35 to 40 minutes long. This allows for a five to ten minute break between groups. Thus, groups begin at 4 p.m., 4:45 p.m., 5:30 p.m., and 6:15 p.m. Counselors begin groups promptly at the start times noted. The break between groups allows for the counselor/group leader to be prepared to begin on time. Break time also gives adolescents a chance to socialize and may decrease their desire to socialize during group time.

Mondays and Tuesdays often have the highest number of adolescents scheduled for groups. Both an OP group and an IOP group are scheduled in each time slot, and both groups complete similar curriculum. This format separates adolescents who are, in general, at different stages of recovery and allows for smaller groups. IOP adolescents are usually at an earlier stage of recovery than OP adolescents. Typically, these adolescents do not see their substance use as a problem, they blame others for their problems, and they engage in "war" stories that glorify using. Chestnut clinical staff have found that separating adolescents based on their stage of recovery is most beneficial to the adolescents as a whole.

IOP adolescents generally attend groups on Mondays, Tuesdays, and Thursdays. OP adolescents generally attend groups on Mondays and/or Tuesdays. Aftercare adolescents (i.e., those adolescents who recently successfully completed residential treatment) attend groups on Wednesdays. OP adolescents who progress and develop a recovery attitude usually are required to attend Wednesday groups only during their last month or two of treatment. Typically, they have been in Monday and/or Tuesday groups for three to four months prior to moving to Wednesday groups. The three different tracks of group schedules allow for a more individualized approach to treatment.

Skills groups are led by a primary counselor and other outpatient staff. Areas of expertise and interest determine who leads particular group modules. The recreation staff frequently lead leisure education skills groups. The outpatient counselor assistant sits in on most groups, except when he or she is leading the drug education groups. He or she is empowered and encouraged to participate as a co-counselor/group leader. The goal is for adolescents to view the outpatient counselor assistant as a part of the treatment team, not just "the driver" or the "urine screen person."

Types of Skills Groups

A weekly schedule of all skills and counseling groups can be found in Appendix F, and materials for the skills groups can be found in Appendix C. Each skills group module includes at least 12 different group presentations. Also, many group presentations have an alternative presentation. While the curriculum provides significant structure and direction for the group presentations, as noted above, the group leader has the flexibility to vary the approach based on individual adolescent needs. Many adolescent issues can be related back to the respective skill group topic (e.g., relapse prevention, self-esteem, relationships, anger management) after the adolescent or adolescents talk about a particular issue.

There is not a specific skills group module that addresses family issues. This important topic is incorporated into other modules. Family issues are addressed in virtually all of the modules as they relate to the respective topic.

The following descriptions of the various skills groups are excerpted from work by Godley, Risberg, Adams, and Sodetz (2003).

Orientation Groups (HOW and Beginnings). There are two types of groups to orient adolescents who have little or no prior experience in substance abuse treatment. The Beginnings groups provide an overview of treatment expectations including how to behave in group counseling situations, how to bring up issues, and how to assertively confront and support peers. It also provides information about recovery groups outside of CHS and introduces the 12 Step philosophy including the concepts of acceptance, powerlessness, denial, unmanageability, and spirituality. HOW groups are specifically designed for those who are resistant to treatment. The goal of those groups is to help adolescents commit to being honest, open, and willing to participate.

Drug Education. This is a didactic group providing information about drugs and alcohol, specific behavioral and emotional effects of chemical use, and driving under the influence of alcohol (DUI education). It is targeted at adolescents who have had minimal prior substance abuse education. Activities include viewing and discussing educational videos, completing written treatment work, and participating in games designed to increase adolescents' knowledge of substance use and its consequences.

Relapse Prevention. The purpose of this group is to help adolescents identify problem situations and substance abuse triggers that occur in their daily lives. The concepts of relapse, substance use triggers, high risk situations, and relapse prevention are introduced. Based on analyses of their individual situations, adolescents are helped to develop recovery/survival plans that are customized to individual needs. The adolescents usually complete a chapter each week in the *Adolescent Relapse Prevention Workbook* (Daley & Sproule, 1999).

Life Skills. This is a didactic group that includes instruction for a number of life skill areas. Topics addressed include basic health care, job-hunting, budgeting, and educational-vocational activities. The group is interactive and often involves discussion and role-playing. Occasionally an outside speaker presents to the group.

Self-Esteem. This group is designed to increase each member's self-awareness, self-esteem, and healthy coping strategies. Activities include reviewing videos, role playing, art therapy, and guided visualization.

Leisure Education. These groups involve therapeutic recreational activities that build the following skills: ability to identify pro-social activities, self-esteem and self-awareness enhancement, positive risk taking, appropriate self-disclosure, cooperation and team work, assertiveness, communication, and stress management.

Emotions/Communication. These didactic groups are designed to help adolescents develop assertive, expressive, and open-minded communication skills and to communicate a recovery image.

Working Recovery/Decision Making. These groups focus on helping adolescents maintain recovery. They might be described as "advanced relapse prevention." Adolescents in these groups have already learned many of the skills and concepts of recovery. Support networks; AA/NA/CA; habit control; developing a "recovery image;" and dealing with drug-using friends, family, and situations also are addressed.

Adolescents develop and implement a recovery plan that can and should be followed after treatment. Adolescents also review decision-making skills and practice making recovery-oriented decisions.

Art Therapy. This group is for adolescents at all stages in their recovery efforts. It introduces fun and creative ways to learn new skills and express feelings. Art therapy strongly encourages self-expression. The counselor reinforces self-expression and creativity, not artistic ability.

Group Counseling. Counseling groups provide opportunities for adolescents to bring up personal issues. Adolescents are encouraged to focus on how they can effectively deal with problems or issues in their lives. Peers are asked to give feedback and relate issues to their own personal experiences. There is an all male and an all female counseling group each week.

Preparing for and Leading a Skills Group

Group leaders prepare for a skills group by reviewing the session guidelines beforehand. In addition, they get to the group room early and sit and listen to adolescent interactions prior to the start of the group. Adolescent "small talk" can often provide a segue to the group topic. A quick overview of the group's purpose/goals orients the group participants to their task at hand for that respective group. The group leader then leads the adolescents through the lesson plan. Whenever possible, the group leader asks for and incorporates adolescents' personal examples to make the topic more relevant to the group members. The group leader strives to engage all the participants and encourages each participant to talk about how his or her experiences relate to the topic at hand.

Skills Group Activities

A review of the curriculum in Appendix C shows that various activities are used to help the adolescents understand the respective group topics. The goal of these activities is to enhance the adolescent's interest and understanding through participatory learning. The activities include

written exercises, games, videos, movies, readings, role playing, short lectures/explanations, and guest speakers.

Attention to Individual Needs During a Skills Group

Counselors are trained to be aware of the cognitive/developmental level of the adolescents in each group. Adolescents vary in their ability to read and in their ability to understand abstract (versus concrete) concepts. Whenever possible, adjustments are made to accommodate specific adolescent issues. Counselors are also expected to be sensitive to situations that might embarrass an adolescent in front of his or her peers. For example, it may be as simple as not asking an adolescent to read or giving all adolescents the choice of reading. The group leader can pose questions that can be answered with a concrete answer—that do not require a more abstract thinking process. Unfortunately, some adolescents will key in on other people's deficiencies and ridicule them. The group leader is expected to intervene quickly in this situation, not necessarily as an advocate for the adolescent, but in a manner that stresses respect and acceptance of all people. This tends to take the focus off the adolescent who may be feeling attacked. In reality, most adolescents who are ridiculed often shrug off or minimize the derisive comment. Regardless, the group leader seeks to communicate to the participants that these types of comments are not appropriate and do not help anyone.

Ending a Skills Group

As a group ends, leaders often ask participants what they learned from the group. Doing so provides the opportunity for the leader to assess the effectiveness of the presentation and reiterate the important points/goals of the session. The counselor could end the group by asking each participant to give an example of how the group topic might relate to them in the coming week. This helps reinforce the relevance and purpose of the group.

VII. Group Counseling with the Adolescent

Group counseling is provided each day that skills groups are held, Monday through Thursday. OP adolescents typically attend one or two counseling groups per week, and IOP adolescents attend three counseling groups per week. Since the primary purpose of skills groups is to teach new skills in a structured manner, counseling groups are intended to provide a non-threatening atmosphere in which adolescents will feel comfortable enough to bring up personal issues. During counseling groups, adolescents are encouraged to focus on how they can effectively address problems or issues in their lives. Adolescents are asked to give feedback and relate the issues discussed to their own personal experiences, particularly on an emotional level. The counseling group process provides the opportunity to discuss real life situations that can range from stressful to satisfying. Talking about these situations in a group allows members to help and learn from others. We believe that learning to help others leads to spiritual, cognitive, and behavioral growth in a socially desirable direction. Alleviating or decreasing emotional pain allows adolescents to focus more easily on not using and developing a recovery lifestyle. Group counseling also has benefits for adolescents who have dual diagnoses. Psychiatric issues can be very debilitating and make it more difficult for the adolescent to change their using behaviors (e.g., major depressive disorder, ADHD, PTSD, conduct disorder, anxiety disorder). In combination with psychiatric care and medications, group counseling can provide support, hope, and direction to an adolescent struggling with a psychiatric illness. Other adolescents and the group leader can provide unconditional positive regard. Feeling accepted and understood, and knowing that others are dealing with similar problems can help an adolescent face their issues with more confidence in their ability to change their behaviors.

Format for Counseling Groups

Counseling groups are the same length as skill groups: 35 to 40 minutes. Counselors were initially concerned that this time period was too short for a counseling group, but they quickly adapted to this time constraint. Adolescents rarely comment that any group is too short in length. Counseling groups are open-ended and new adolescents enter the group nearly every week. Group rules are reviewed at the beginning of a counseling group approximately one time per month. Respect for others is the principle that underlies most of the rules. After the group

leader reviews the "Contract for Group Behaviors" (see Appendix F), each adolescent signs the behavior contract. Adolescents are often reminded that the outcome or value of the counseling group is dependent upon them, and that the purpose of counseling is to allow them to bring up issues in a non-threatening atmosphere.

Beginning the Group

Sometimes it is difficult to get a discussion started in a counseling group. A level of trust must be established for most adolescents to be willing to self-disclose and talk to a group of peers and a counselor about personal problems. Thus, a prerequisite to developing productive counseling groups is building trusting relationships among group members. There are many trust-building group exercises that can help the adolescents feel more comfortable and open with each other. A simple yet effective strategy to promote trust is ask adolescents to talk about their strengths, or what makes them or their family unique, or why they are in treatment, or what is their drug of choice and why. These simple questions often lead to discussions, and the process of learning, or being willing, to talk about one's self in a group counseling situation. These types of questions help the adolescents see their similarities, and this increases their level of comfort.

Since counseling groups are open-ended and new adolescents enter the group nearly every week, it is common to begin counseling groups with a question that each adolescent answers. If no counseling issue emerges from the initial questions and answers, the counselor may remind adolescents that it is their group—they need to bring topics to the counseling group. It is sometimes helpful at that point to ask an adolescent who has been in treatment a relatively long time to identify some of the issues that have been discussed in past counseling groups or to remind adolescents of issues they talked about in previous groups. It is also beneficial to have the older adolescents identify how counseling groups can be helpful, or how counseling groups have helped them. Adolescents have stated that counseling groups have helped them be more open with teachers and their parents, and helped them realize that others struggle with similar issues. Adolescents have said that they feel less stressed after talking about their problems in counseling groups.

When adolescents have difficulty bringing up an issue for discussion, the counselor may bring up the topic of trust, acknowledging that it is hard to talk about personal issues with others that they do not know well or do not yet trust. Another technique that counselors have found to

be helpful when adolescents have difficulty bringing up topics is to remind participants that they can work on their treatment goals in the group. Examples of the goals include: (a) talking about the role of peer relationships in recovery; (b) trying to be more honest; (c) working on anger management; (d) defining short and long term goals and making a plan to accomplish the goals; and (e) talking about the problems in their life that are related to using substances. The following example of a counseling group helps to illustrate what one is like:

> Eight adolescents were present, including two who were attending for the first time. After the group leader introduced himself and briefly explained the process and purpose of counseling groups, he asked adolescents to introduce themselves and tell what led to their entering treatment. The adolescents talked about legal involvement, dirty urine screens, getting expelled from school, and parental pressure to stop using. Several adolescents blamed the legal system for their problems. At this point, the leader asked a more seasoned adolescent, who had accepted responsibility for his problems, to talk about his legal charges and what had helped him accept that he was responsible for this actions. The adolescent began by saying that be understood how the others felt because he used to feel that way. He came to see using as his problem when he took an honest look at how using had affected his life: legal, school, family, job, and girlfriend problems. Then he talked about how smoking cannabis made him lazy. He ended by naming ways that his life was better since he stopped using.
>
> The leader asked one of the new adolescents if he had any problems like the other adolescent had just talked about. He talked about school and legal problems, then stated that cannabis should be legalized. The leader asked how legalizing cannabis would help his school grades, make him less truant, affect his driving skills, and affect his non-substance related legal charges. When he said nothing, another adolescent began talking about how cannabis made him lazy and not care about anything in his life, agreeing with statements made earlier by another adolescent. He also said he could remember things better now that he stopped using.
>
> At that point, the leader thanked the group members for their introductions and comments, and noted that the discussion was an excellent example of how to use counseling groups. The leader mentioned the importance and value of being honest, and

that counseling was not about telling the leader things that they thought he wanted to hear. The leader then asked if anyone had a topic that they wanted to discuss. An adolescent said that he had court the following day and was not sure what was going to happen to him. He was worried he might go to jail. Four adolescents asked him questions about his legal involvement, and in the process, talked about their experiences in court. The leader occasionally asked questions such as, "Were you worried? Were you scared? How did you feel the day before you went to court? How can you avoid having to feel this way in the future?" The group leader then pointed out that the adolescent was doing things that the judge would look favorably upon: going to treatment, leaving clean urine screens, and going to school. The leader then mentioned that the group was about over and asked if there were any final comments. Several adolescents wished the adolescent "good luck" and said they hoped to see him next Tuesday in groups.

Often when an adolescent is successfully discharged, a counseling group serves as the final place for good-byes. The leader will begin by summarizing the adolescent's positive changes while in treatment. Other adolescents are encouraged to comment on the changes they have seen or to say whatever they want to the adolescent who has successfully completed the program. Very often the adolescent who is leaving offers hope to the others that they too can successfully complete treatment. This situation is really a wonderful counseling opportunity to explore feelings of happiness and sadness. Many successfully discharged adolescents are also willing to express their fear at now being "on their own."

Keeping the Group on Target

Optimally, discussions in counseling groups should concentrate on discussing cognitions and emotional feelings related to trying to achieve goals. Occasionally, adolescents will begin talking about topics in a way that is inappropriate. If an adolescent begins describing a situation and follows an undesirable direction, the counselor tries to help the adolescent understand the importance of reframing the discussion. For example, an adolescent may begin talking about a party that he or she attended where there was alcohol and drugs. Rather than just relating a war

story (i.e., glorifying using), the adolescent would be asked to talk about his or her feelings and how this affected their recovery process.

Ensuring Full Participation

Counselors work to ensure that all adolescents have an opportunity to be a part of group discussions. Adolescents are more likely to join in when the counselor communicates a non-judgmental attitude. When the counselor is aware of each adolescent's history, he or she can help make the connection between the topic at hand and an adolescent's experiences. Adolescents can still be gently confronted, but not until they have developed a positive relationship with the counselor and other group members.

Types of Counseling Groups

There are not different types of counseling groups in the same sense as there are different types of skills groups. The content or topics of discussion are dependent on what issue adolescents want to talk about. While most counseling groups tend to focus on the emotional aspects of issues, they sometimes are similar to a skills group. A discussion may evolve into defining relapse prevention strategies, or decision-making skills, or dealing with withdrawal symptoms. Counseling groups can include skills building. It is important for the counselor to bring the group back to a more open discussion format after a few minutes of a more didactic format. Our experience suggests that adolescents seem to be more comfortable with skill building discussions, rather than talking about more emotional-laden counseling issues.

CHS provides gender-based counseling groups. In these groups, males and females are separated and they attend their own counseling group one time per week. These groups give adolescents an opportunity to bring up issues that they might find difficult to bring up with the opposite gender present. Females appear to appreciate this format more than males. The format for gender counseling groups is not different from typical counseling groups that include both males and females.

Ending the Group

Counseling sessions often end when the counselor states that it is about time to conclude and asks the adolescents if they have any final comments. Sometimes those adolescents who

brought up topics are asked if they got what they needed from the group. Often the counselor may identify one or two adolescents who participated well on a personal level in order to help the other adolescents understand the expectations of group members in counseling.

VIII. Family Night

Based on prior research and our own experience, Chestnut believes that involving families in the treatment process can help adolescents recover from substance use (Kaufman, 1994; Liddle & Dakof, 1995; Stanton & Shadish, 1997; Steinglass, 1994). Getting families to participate can sometimes be a challenging task because parents often have time constraints or other areas of their lives that require attention. One Chestnut intervention that aims at increasing family involvement is the Family Night program. During Family Night, multiple families and interested collaterals meet together with the goal of better understanding the issues that are common to families who have an adolescent with substance abuse problems. The Family Night program offers both education and support and is presented every Tuesday night from 6:00 p.m. to 8:15 p.m. Attendance at Family Night is open. That is, families can start attending any week and may attend whenever they wish, although they are encouraged to attend as long as their adolescent is in treatment. Families can attend even after their adolescent has been discharged, although this is not common.

First Hour of Family Night (Informational Sessions)

During the first hour of Family Night, when the adolescents are in their skills groups, counselors provide information on a variety of topics to the parents/collaterals. These topics include family roles, drug education, relapse signs and prevention, denial, enabling/detachment/parenting styles, coping styles, adolescent development, emotions, communication, the 12 Steps and self-help groups, and HIV/AIDS education. The following are short synopses of 10 Family Night topics, which are presented in a 10-week cycle.

Family Roles/Sculpture. Participants learn about how a person's addiction can affect other family members and take control of the family. Typical roles of non-using family members (e.g., hero, scapegoat, lost child, chief enabler, mascot) are discussed. Family members are asked to participate in a family sculpture/role play that is directed and orchestrated by the counselor. A discussion follows.

Drug Education. Participants are provided with information on the physiological and psychological effects of the more commonly abused substances. Typically, one or two residential adolescents are available to answer questions about substances.

Relapse Prevention. Participants are taught about factors related to relapse, including the most common relapse triggers. Family members are encouraged to talk with their adolescent substance abuser about relapse prevention and how they can help him or her maintain sobriety. Parents/guardians are led in a discussion about what they can and cannot change and what they can and cannot control. Participants are also told that the optimal situation is for an adolescent to avoid relapse. If relapse occurs, it is not a sign of failure or that the adolescent did not profit from treatment. Parents are encouraged to help their child learn from a relapse experience and move forward.

Denial. Participants are taught about the role of denial in chemical dependency and why it is important to address denial early in the adolescent's treatment experience. The group leader explains different ways in which denial manifests itself (e.g., blaming, anger, rationalizing, minimizing). Participants are told how staff gently confront and question adolescents in trying to decrease their level of denial and increase their level of motivation to stop using. Sometimes a video is shown that demonstrates both denial and enabling behaviors.

Enabling/Detachment/Parenting Styles. Parents are educated about enabling and told it is a common reaction to adolescent substance abuse. Parents, teachers, and even police enable substance abusers. Enabling is understandable, but rarely produces the desired effect of abstinence in the substance abuser. Reasons why people enable and how enabling prolongs substance abuse are reviewed. Three parenting approaches are discussed: detached, consistent, and structured. Parents are told that "detaching" from their adolescent means that they allow natural consequences of their adolescent's behavior to occur. This parenting approach is one we believe helps the adolescent to stop using. Detaching (i.e., maintaining emotional distance between the adolescent and the parent) is similar to the "tough love" concept. Loving the child does not include condoning inappropriate behaviors. Consistency

and structure are also emphasized as important parenting approaches that will help encourage healthy behavior in their children.

Coping Styles. The MMPI-A (Minnesota Multiple Personality Inventory–Adolescent) clinical scales provide the framework for this presentation. Participants learn about the different ways people cope with their feelings and stress (e.g., depression, somatic symptoms, avoidance, anger, paranoia, psychosis, anxiety, substance use).

Adolescent Development. Participants learn about the issues that young adults deal with, both cognitively and behaviorally, and their developmental limitations. The effect of developmental issues on treatment interventions are discussed.

Emotions. This group helps participants understand the importance of being able to identify feelings and to talk about feelings with their adolescent.

Communication. Typical communication problems with substance-abusing teenagers are addressed. Participants learn about the importance of active listening to help alleviate communication problems. Parents are asked to look at how they may contribute to communication problems with their adolescent.

The 12 Steps/Self-help Groups. The basic concepts of AA/NA/CA (e.g., acceptance, honesty, Higher Power) are explained and related to recovery. The participants learn why attendance at self-help meetings is strongly encouraged for many adolescents. Parents are told how self-help meetings are typically conducted. Parents are also told about Alanon meetings, and family members are encouraged to attend these self-help meetings.

The following example helps illustrate the mechanics of a Family Night presentation (6:00 to 7:00 pm). The presentation focused on denial.

After introducing himself and presenting an overview of the Family Night program, the group leader encouraged questions and comments from the participants at any time during

the presentation. The leader then identified several goals: an understanding of the concept of denial and how denial is manifested (i.e., types of denial), and ways to decrease denial. A two-page handout was distributed that contains a definition of denial, why denial is such a significant issue to address, different types of denial, the purpose of denial, and strategies to deal with denial. The participants are often asked to give personal examples of how the adolescent's denial system has been manifested. Very often parents expressed feelings of frustration, anger, and hopelessness in response to their son's or daughter's continued substance use despite serious life consequences. The group leader involved as many families as possible in discussing the common feelings that cross family lines. The leader helped families realize that they are not alone in their struggles. The leader also tried to impart a realistic hope that adolescents can and do change, but that for some adolescents, it can be a very long process often involving several treatment episodes.

The group leader then discussed how CHS staff members deal with denial. Denial is conceptualized as a lack of motivation to change. Therapeutic techniques attempt to increase the adolescent's motivation to change. Parents are asked to describe how they have attempted to deal with denial and what seemed most helpful to their sons or daughters. As the group ends, the leader reviews the goals that were identified at the beginning of Family Night. Parents are asked if they feel the goals were accomplished, and also for any last questions or comments.

Another example of a Family Night presentation follows which concentrated on reviewing "Coping Styles."

A lengthy handout on eight coping styles was distributed to the participants. The group leader discussed each coping style and the behaviors and cognition that define the style. The coping styles are derived from the MMPI-A clinical scales (e.g., depression, anxiety, anger/rebellion, paranoia, schizophrenia, etc.)

Parents frequently focus on themselves (versus the adolescent) as they review the coping styles. They gain insight into why they react as they do to stressful situations. The group leader encourages the participants to consider how their coping styles might interact with the coping styles of their sons or daughters. The presentation addresses the common question

asked by many parents: why does their son or daughter abuse substances? Parents can better understand how using substances satisfies personal needs related to one's coping style or styles. It is stressed that personality (i.e., coping style) is not changed by treatment, but that adolescents learn alternative ways of satisfying their needs rather than using. Parents are encouraged to talk with their sons or daughter about coping styles and how he or she is going to satisfy their needs (e.g., need for excitement, avoiding boredom, feeling lonely or depressed or angry, feeling anxious, feeling distrustful). The group ends after giving the participants a chance for any final comments.

Regardless of the topic, the group is always encouraged to ask questions and make comments. Group leaders frequently ask questions and attempt to involve the participants by asking for personal examples. Data from a study on Family Night participation revealed that the more attendees actively participated or believed that they participated, the more they felt helped and the higher they rated the helpfulness of the respective presentation (Risberg & Funk, 2000).

Second Hour of Family Night (Multifamily Counseling Sessions)

After a fifteen-minute break from 7:00 p.m. to 7:15 p.m., the second hour of Family Night begins. The second hour is a group family counseling session. While both residential and outpatient families attend the first hour together, the two groups are split for the counseling groups that follow from 7:15 p.m. to 8:15 p.m. Adolescents attend the multi-family counseling session along with family members and/or friends. Typically, two outpatient counselors lead the counseling group.

Counselors strive to make the family counseling groups feel comfortable and informal. Counselors are in the group room as the adolescents and their families arrive so that they can initiate conversations with various members. After the break time is over, the counselor announces that it is time for the group to begin. All members are asked to introduce themselves, and the counselor begins this process. A counselor then describes how counseling groups function: anyone can bring up a topic or issue, and group members are encouraged to bring up positive changes and strengths as well as problem areas. The topics addressed are dependent on the needs of the families. Occasionally, group members have difficulty bringing up the first

issue. A productive way to "get the group going" is for the counselor to ask an adolescent or parent about an issue that was discussed the previous week.

The Family Night counseling group is usually conducted in the stereotypical counseling group manner. The group sits in chairs placed in a circle. Most groups range from 12 to 20 participants. As previously noted, the responsibility for group content/topics is placed on the adolescents and family members. The counselors encourage feedback from other group members after an adolescent or family processes an issue. Counselors may ask if anyone else in the group has had to deal with a similar issue and to discuss how he or she dealt with it. Occasionally, a group member will direct a question to a counselor. Since the focus of group counseling is for the group members to talk with each other, these questions are answered in as concise a manner as possible. Frequently the counselor can direct the question back to the group and, in a sense, seek feedback from the group.

Ending Family Night

When the hour is over or when there is a natural break in the discussion near the end of the hour, the counselor notes that the group time is about over. The counselor asks if anyone would like to bring up anything else or make a final comment. The counselor may then summarize the main issues discussed. Participants are thanked for coming and encouraged to return the following week. Often, some parents will stay after group for ten or fifteen minutes and continue to talk with the counselors. Since some people have a difficult time talking in groups, it is important that counselors provide this opportunity for parents.

IX. Family Counseling

In addition to encouraging Family Night attendance, primary counselors are expected to strongly encourage families and adolescents to participate in individual family counseling sessions. Parents are often quite frustrated, angry, afraid, and ill-prepared to help their son or daughter develop a drug-free lifestyle. Family counseling can assist with improving communication skills and problematic interpersonal dynamics, focusing on positive changes, and helping family members learn how to be supportive and respectful of each other. It also provides the opportunity for counselors to assess the need for and refer families to other community supports.

While family counseling is available for all families, not all families are willing or able to participate in family sessions. The most frequently attended family sessions take place at the same time as admission. Contact during this session provides counselors with the opportunity to attempt to schedule a second family session. Counselors are also encouraged to have family sessions to review the MTP. Some families may have only one or two sessions, while others may meet on a weekly basis with the counselor. The following provides discussion of topics and strategies commonly addressed in family sessions.

Format for Family Counseling

Family counseling sessions typically last from forty-five minutes to an hour in the counselor's office. The adolescent and family are asked to bring up any issues or concerns they may have. Very often, the counselor helps the family improve their listening skills. Initially, it is common for members to interrupt each other. Adolescents often complain that their parents do not listen to them and that they do not really understand them. Counselors can help by repeating what the adolescent says until the parent hears it and vice versa.

Admission Sessions

Initial paperwork (e.g., Initial Treatment Plan) is completed at the admission session with the adolescent and usually one parent attending. The paperwork often leads to questions about the treatment process. After reviewing the results from the GAIN assessment, the counselor continues to assess for problem areas and possible treatment goals. It is very telling

when the counselor asks the adolescent what goals he or she would like to work on while in treatment. Many adolescents are not aware that treatment is more than stopping drug and alcohol use. Parents are glad to hear that treatment addresses problems such as anger management, psychiatric problems, family issues, communication, school problems, and behavior problems. The counselor lets the adolescent and family know that change is largely dependent on the adolescent, but that there are some things that Chestnut and the parents can do to help the adolescent make changes. The adolescent is told that he or she will be required to meet staff and his or her parents halfway and that the responsibility for change primarily lies with the adolescent.

For any problem discussed, the counselor can ask both the adolescent and family members to identify any small changes that would indicate some positive movement in working on the respective problem. If the adolescent wants some house rules relaxed such as curfew or time on the telephone, this issue might be framed in terms of trust. For example, what could the adolescent do that would increase the parent's level of trust in the adolescent? Conversely, what is the adolescent willing to do? Behavioral changes, whether the adolescent's or family members', need to be specific and attainable. Goals are defined as clearly as possible and not set so high that they will be very difficult to attain. Simple behavioral contracts are excellent formats for helping all family members see the importance of clear communication and clear expectations.

Referring to Other Community Supports

During the initial family session and in subsequent sessions, counselors assess the need for and encourage parents to use additional community supports including school counselors, teachers, coaches, religious leaders, probation officers, family, relatives, doctors, mental health counselors, psychiatrists, Alanon, and AA/NA/CA. When appropriate, referrals are made to community-based programs designed to meet specific needs such as pregnancy, housing problems, financial problems, recreational needs, and medical needs. Parents sometimes expect the treatment experience to "fix" or "cure" their son or daughter. Counselors help parents understand that recovery is a process and that treatment is just the beginning of the process. The knowledge that there are many community resources for both the adolescent and themselves decreases fears and affirms that they are not alone in their efforts.

Master Treatment Plan Review Family Sessions

Since an important goal of family counseling is to involve family members in the adolescent's treatment process, a relevant activity is a periodic review of the adolescent's MTP goals and discussion of any progress that has occurred. Virtually all adolescents have MTP goals addressing family issues such as improving communication, behavioral and attitudinal issues, house rules, and job duties around the house. Occasionally, parents do not recognize or are unwilling to see positive changes in their son or daughter. The counselor can help the family begin to be more sensitive to the adolescent's efforts at changing his or her behaviors. Prior to treatment, parents often dealt with the negative behaviors of the adolescent on a daily basis. Addressing pessimistic expectations, fostering hope, and providing direction/goals are effective change mechanisms for both adolescents and family members.

Homework Assignments

An intervention that counselors are encouraged to use is adolescent and family homework assignments that can lead to small, positive changes. The counselor works to frame homework in a positive light. Adolescent homework examples might include: cleaning his/her room each day, saying something nice to each family member every day (complimenting), attending school every day, doing homework every night, not swearing while in the home, eating a meal with the family, or playing with a smaller brother or sister. Parent homework examples might include: not mentioning doing specific chores that the adolescent agreed to do (at least until a week had passed or the next family session), complimenting the adolescent every day, only mentioning adolescent chores in the context of complimenting the adolescent on completing them, not complaining or saying anything if the adolescent sleeps in on Saturday, doing something with the adolescent that the adolescent wants to do, or writing down the behaviors that the adolescent does that increase trust.

Rebuilding Trust and Addressing Peer Relationships

Parents are commonly concerned about two issues: being able to trust their adolescent again and the influence of negative peer relationships. MTP goals address both issues for most adolescents. Trust is an issue that causes worry and frustration for both parents and adolescents. Adolescents are often frustrated because they feel that parents do not let go of the past and that

they make unreasonable demands for them to gain freedom (i.e., a later curfew, going out with friends, having their own phone). The counselor needs to help the adolescent understand that earning back trust is a process: that they need to "prove" their honesty through different behaviors. Counselors can help the family and adolescent to identify specific adolescent behaviors that would "prove" the adolescent's trustworthiness. These behaviors might include doing chores as expected, coming home on time, not being late for or missing any work or school, paying debts on time, and in general, not lying about anything. A schedule/contract can be developed that identifies parental expectations related to trust-building and the "freedoms" that can be earned if the adolescent follows through with the expectations. The counselor may need to help the parents be realistic in their expectations and to understand that some risk is a natural part of trust-building. For example, it is not realistic for the parents to expect six months of curfew compliance before they consider raising the curfew. Two to four weeks of compliance should result in some change, even if the change is small (e.g., fifteen minutes). The counselor helps the family to define relatively small, objective, attainable behaviors that demonstrate adolescent movement in the trust-building process.

Following is an example of dialogue from a family counseling session. Building trust between the adolescent and his parents is the issue. The adolescent is a 16-year-old male who was in IOP for four weeks and was then transferred to OP. He had been in OP for about one month when this session took place. Both biological parents were present. The counselor is reviewing the adolescent's progress in addressing MTP goals.

Counselor: *John, tell me about your family goals. Have you been trying to change any of your behaviors around the house or in talking with family?*

Adolescent: *Yeah, I've been doing my chores—almost all the time. And when they [parents] ask me to do something, I do it. I've been trying to cut down on swearing. They don't like it, and I don't like it when I hear my little brother swearing. I know I've cut down a lot.*

Counselor: *Wow! That's great! What else have you tried to change?*

Adolescent: *Well, I used to come home really late, sometimes not till the next day. I've been coming home when I said I'd get home. They [parents] used to call my probation officer about every week, saying I violated my curfew. I know it's been over a month since I was late.*

Counselor: *It sounds like you are really trying to follow rules and get along better with your parents. [To the parents] Have you noticed these changes in John?*

Father: *Yeah, I think John is trying to get along better. He is slowly earning back our trust in him. He lied to us so many times before that I still sometimes wonder if he is sincere. I try to be optimistic, but sometime it's hard.*

Counselor: *Building trust does take awhile. John has started developing a new habit of being honest. And it will take a while for you to develop a new habit of trusting. John needs to prove himself. I think he is doing a pretty good job of making an effort to earn back your trust. Has John's honesty earned any privileges?*

Adolescent: *Yeah, I got to go out with my friends last Saturday, and my mom took me driving so I can get my license in a month or two.*

Mother: *I enjoyed it. It was fun doing something with you. Back when you were using a lot, I never even saw you very much. That's a positive change I really appreciate. Although I still worry that you will go back to using, I am a lot less worried about you now.*

Counselor: *How do you feel about the changes John has made [looking at father]?*

Father: *Well, he is a lot easier to live with. I'm a lot less angry and worried. I really want to believe his changes are permanent; that he is sincere about not using; and not worry about the police coming by and asking questions. I can't forget all the bad things that happened to our family because of John's using drugs. I do feel a lot more trust in him than I did a couple of months ago. I'll feel even better—more trusting—in a few more months. He's on the right track. It is going to take a while for him to earn back the trust he used to have.*

Counselor: *John, how do you feel about what your father said?*

John: *I guess I understand. But sometimes it doesn't seem fair when they hold things over my head—like getting my driver's license. I don't think I should have to wait until they say I can get it.*

Counselor: *They have high expectations of you, like wanting to be sure you have stopped using. If you had a son in your shoes, how long would you wait to see if the changes were permanent or just temporary?*

Adolescent: *I don't know. Maybe a few months.*

Counselor: *Okay. Let's see. It has been a few months since you used. Maybe you and your parents can work out something about what you can earn back in the next few months. John, would you write out all the changes you are making that you feel prove you are more trustworthy? I would also like you to think of some new ways that you can show you are trustworthy; things you can do in the coming weeks. Then sit down with your parents and talk about what you might earn if you follow through with the behaviors. Maybe you can work out a schedule that shows what you can earn each week if you follow through. Would you all be willing to do that? [They all say yes] Remember John, negotiating with your parents is about working together. Hopefully everybody can get some of what they want.*

Adolescent: *So we will sort of write weekly goals. That will probably help me stay focused on what I need to do.*

Counselor: *Yes. And the more you do what you say you are going to do, the more your parents will trust you.*

Peer relationships are also high on the list of parental concerns. The adolescent often wants to continue seeing old friends who still use alcohol or drugs, or at least some of them. Counselors may propose a compromise that would allow old friends to come over to the adolescent's home to visit when parents are home to supervise. Many parents are not comfortable with a compromise, because they do not want to allow any of the adolescent's old using friends in their homes. The treatment program emphasizes that associating with using friends is risky. However, it is very important that the adolescent find new, non-using friends to replace the old friends. The counselor can help the family explore where new friends might be found (e.g., AA/NA meetings, school activities, hobbies, family members, church) and how the adolescent might access them. It is common for parents to blame the adolescent's friends for their son's or daughter's substance use problems. The adolescent often vehemently denies that the friends made them use substances. The counselor can reframe the issue in terms of risk: it is not that the friends make anyone use with them, but that the odds are a lot higher that a person will use when they are around users versus non-users. The counselor can help the adolescent hear and understand their parent's fears about these friendships. One counseling strategy that is often helpful is to create two lists of friends: those that support recovery and those that do not. Privileges (i.e., "freedoms") can be linked to time spent with the friends who support recovery.

Summary

The counselor helps the family understand that the adolescent's recovery process is partly their responsibility and that at the same time, many of the adolescent's behaviors are not under parental control. Parents can set consequences for certain behaviors, but the adolescent is in control and responsible for his or her actions. Counselors also help develop more effective parenting skills. For example, parents are encouraged to follow through with consequences (i.e., be consistent). Family sessions are also beneficial because they reinforce the MTP goals that address the adolescent's behaviors outside of the treatment facility (i.e., at home, school, a job, when with friends). The family is typically more informed about the adolescent's behaviors across domains. It is therapeutic for the adolescent if all professionals, family members, and collaterals are aware of the adolescent's progress and difficulties. Adolescents need to understand that recovery involves all aspects of their lives and that their treatment goals reflect this.

X. Troubleshooting: Strategies for Common Clinical Problems

There are several recurring clinical problems or challenges that surface when counseling adolescent substance abusers. To ensure consistency and structure, CHS follows general guidelines/interventions across all adolescents. Since the primary modality for CHS treatment is through groups and leaders vary by group, these guidelines are especially important. All staff, not just the respective adolescent's primary counselor, can immediately address a problem. When problems surface in the context of skills or counseling groups, the group leader can pursue the problem at that time. The primary counselor often discusses the problem again with the adolescent individually. The treatment team constantly works to communicate to all team members the problems of each specific adolescent. After a staff member addresses a problem with an adolescent, he or she lets other staff members know about the situation, especially the adolescent's primary counselor. The following sections describe typical interventions used to address the most common clinical problems.

Late for Sessions

When an adolescent and his or her family attend the initial admission session, they are told that groups start promptly at 4 p.m. and that no one is allowed into a group after 4 p.m. If an adolescent is late, he or she must sit in the lobby and wait for the next group, which begins at 4:45 p.m. The adolescent would receive the lowest possible group score for the missed group session on the weekly group check sheets that are mailed each week to parents, probation, and any other collaterals for which there is a valid disclosure. The adolescent understands that all professionals and parents will be made aware of their group attendance. This is a "front-end" intervention.

If an adolescent begins to consistently be late for groups (i.e., two days in a row or at least one day per week for two or three weeks), the primary counselor talks with the adolescent about his or her tardiness. The counselor approaches the issue in a collaborative manner. For example, the counselor might ask if there is something that staff can do to help the adolescent be on time. Sometimes the problem is due to transportation problems or a new work schedule for the adolescent. If this is not the case and it appears to be due to the adolescent's lack of responsibility or willingness, it can be helpful to review their MTP goals that specifically address

attending all scheduled groups and earning scores of at least 3. Adolescents who are court-ordered to complete CHS treatment recommendations also have a goal indicating that they will follow their court order. On one hand the counselor offers assistance to help them change their behavior, and on the other hand the counselor reminds the adolescent of the consequences of earning group scores of 1. It is sometimes helpful to compare missing groups to missing school classes. The adolescent is responsible for the material presented. In the case of missed treatment groups, this can result in a longer stay in treatment.

Missed Groups or Individual Sessions

Missing groups or individual sessions is addressed in a similar fashion to being late for groups (see above section). Typically, the primary counselor meets with the adolescent to try and understand why the adolescent is missing sessions. The reasons can include adolescent resistance, parental resistance, transportation problems, or scheduled appointments with probation. Adolescents often forget to tell their counselor about upcoming appointments.

A strategy used to help adolescents realize that they are responsible for group content is to give them homework related to the group(s) that they missed. Individual sessions are rescheduled for another time. Adolescents are also reminded that they are not completing their MTP goals and that this may result in a longer treatment length.

In some instances, the adolescent's group schedule may need to be changed in order to accommodate the adolescent's work or school schedule or a parent's changed schedule. Parents often transport their son or daughter to treatment. The counselor needs to work with the adolescent's and family's schedules. It may be necessary for CHS to transport the adolescent to groups. There is a limit to the number of adolescents that can be picked up and transported to groups by CHS, but whenever possible, this service is offered. Most of the time, the adolescent can be picked up after groups by the parent; the problem is getting the adolescent to groups.

Unwillingness to Attend AA/NA/CA Meetings

Counselors take time to explain to adolescents why attending self-help meetings is an appropriate MTP goal. Counselors acknowledge that attending meetings will not be a long-term recovery behavior for every adolescent after treatment completion. However, every adolescent is made aware of support groups and how to access them if they need to later in life or if he or she

wants to refer someone else to them. Adolescents frequently complain that mostly "old" people attend meetings and they cannot relate to them. Counselors acknowledge that this statement is often true and that it may be difficult for the adolescent to relate to certain topics that will be discussed. For example, the adolescents may not relate to problems with parenting children or divorce. Counselors may point out, however, that the general issue of relationships is something to which they could probably relate. The adolescent may need to see the bigger picture when older people bring up issues and relate on a different level.

Adolescents can relate to the following rationalizations for attending two to four self-help groups while they are in treatment: (a) Meetings do not take much time and the adolescent is accomplishing a treatment goal that helps them get out of treatment; (b) At least half the adolescents who attend meetings say that the meetings are interesting and that they meet people who really understood their life problems; (c) Adolescents need only listen at meetings and do not have to talk about their life or personal problems; (d) Since nearly all adolescents are asked to attend at least two meetings, they can ask other adolescents to go with them; and, (e) If the adolescent is on probation or parole, his or her probation or parole officer will be glad to hear that he or she attended meetings.

It is also very helpful to elicit feedback from those adolescents who have had positive experiences at AA/NA/CA meetings. This strategy can reduce resistance and take advantage of positive peer pressure. Several skills groups directly address the philosophy, mechanics, and value of self-help groups. It is important to present information factually, not in a persuasive manner. If the counselor becomes frustrated with adolescent resistance and is not patient and understanding, adolescents may feel coerced and forced to attend meetings. A willingness to try something new is much more likely to occur when adolescents understand the logic/reasons for attending meetings and feel that if they attend meetings, it is a choice they made.

Glorifying Substance Use

Adolescents often tell "war stories" about their past substance-abusing experiences. They glorify, or in a sense celebrate, past using experiences. This can quickly become a competition among the adolescents. Each tries to out-do the others' stories, whether by amount used, what was used or the combination of substances, where it was used, or the physiological effects of

what was used. War stories serve the purpose of providing a platform from which to brag about past using behaviors.

Adolescents tend to get excited as they tell war stories. This physiological reaction offers an opportunity for the counselor to explain why telling war stories is not appropriate. The counselor might ask, "How does getting excited about using help you to not use?" Or the counselor might say, "No one denies that using is often a lot of fun. But right now you are in treatment because of the problems that using has caused in your life. I know you are trying not to use. Telling war stories usually makes people miss drugging and drinking and forget about all the problems that using causes. Even if war stories do not affect you this way, they may negatively affect others." Another question that a counselor may pose is, "How does telling war stories and glorifying using help you in your recovery today?"

Counselors can also explain the difference between a war story and talking about one's past using history. Very often, an adolescent can be enlisted to give examples of when talking about one's history of using moves into a war story. Virtually all adolescents can understand the difference. Their physiological reaction lets them know if it is a war story.

A related issue that can follow from a discussion of war stories is how the adolescents impress their friends: what do they do or say that brings respect from their peers. Adolescents can identify personality traits and skills that they are proud of and that make them unique and worthy of their peers' respect. Abstinence has taken away a part of their self-image. It is important that adolescents build on their strengths and incorporate personal strengths into their non-using recovery image.

Attending Treatment While Under the Influence

If an adolescent admits to being under the influence of drugs or alcohol while attending groups, the adolescent is told to leave the group and wait outside in the reception area. As soon as possible, a counselor talks with the adolescent about the relapse, but not at length. When someone is under the influence, it is largely futile to try and process and counsel. If the adolescent seems impaired at all or says he or she is high, provisions are made to transport the adolescent home. This may involve calling the parents to pick up the adolescent or CHS may transport the adolescent home. The safety of the adolescent and the public are the main concerns.

The next time the adolescent comes to the facility, the adolescent's primary counselor will meet with him or her individually to discuss the relapse episode. As with virtually all relapses, the adolescent is encouraged to tell his or her parents and probation/parole officer, if he or she has one. A common strategy is for the counselor to give the adolescent two days to tell his or her parents and court officers about the relapse before the counselor informs them. This gives the adolescent an opportunity to be honest and forthcoming about relapsing. Counselors approach relapse as an opportunity for the adolescent to learn about personal triggers and what needs to change in order to avoid another relapse. Processing the relapse may include having the adolescent identify the consequences of continued substance use. Adolescents are encouraged to contact their counselor if they relapse, but not to attend groups while under the influence. If one adolescent in a group is under the influence, it is very disruptive for the other group participants.

During the past five years, there have been very few incidents where the adolescent was noticeably under the influence/high. On one occasion, an adolescent had red eyes and spoke more slowly. However, he convinced the group leaders that he was feeling sick and had a cold in his sinuses and was not under the influence of drugs. When his next urine screen results were positive for cannabis, he admitted to being high on the night he had said he was sick. Even substance abuse counselors have a difficult time identifying someone under the influence of cannabis, the most commonly abused substance.

Low Motivation/Lack of Commitment

The approach proposed by Miller and Rollnick (1991) best describes how staff attempt to address an adolescent's lack of motivation. Chapter five in Sampl and Kadden (2001) also details the rationale and principles of motivational interviewing (Miller & Rollnick, 1991). The job of the counselor is to help the adolescent come to the realization that it is in his or her best interest to try and make some changes. However, the counselor makes it clear that it is the adolescent's choice whether or not to try and make changes in his or her life.

Prochaska and DiClemente (1984) developed a theoretical model that identifies stages of change. The authors suggest that people commonly progress through stages: from a stage of no recognition that problems exist, then accepting that a problem exists, to making a commitment to working on the problem, to actually working on the problem, and finally to maintaining the gains made when they worked on the problem. Motivational interviewing techniques vary by stage.

The initial techniques are often described as mild confrontation. A major tenet of motivational interviewing is that direct confrontation generally increases resistance and should be avoided. The counselor leads the adolescent through questions to reevaluate goals by creating incongruence between the adolescent's behaviors and his or her goals. The counselor tries to develop a relationship based on equality and support, not a doctor-patient relationship.

Opportunities to encourage adolescents to reevaluate their goals (i.e., become more motivated to change) occur in group settings as well as individual and family counseling sessions. Increased motivation occurs when adolescents increase their willingness to look honestly at their life problems and be open-minded enough to evaluate possible relationships between using and life problems. Counselors encourage this through empathy, building trust, concrete feedback, advising (not telling), expressing concern, and offering treatment alternatives. The adolescent is given all responsibility for making changes. TIP 35 from the Center for Substance Abuse Treatment (1999) provides an excellent overview of motivational interventions and how treatment needs vary depending on an adolescent's readiness to change. All counselors are expected to read this publication and incorporate this model of motivation and the stages of change into their counseling approaches. All counselors have attended at least one all-day training on motivational interviewing and stages of change.

Negative Attitude

An adolescent may have a negative attitude for a variety of reasons. A counselor might initially show empathy and concern when asking why he or she is feeling down or angry. The adolescent's response would determine how the counselor would pursue the negative attitude issue. If the adolescent responded that he or she was having a terrible day and then identified several relatively minor incidents, simply listening with empathy and then encouraging the adolescent to focus more in the moment would be one possible response. Depending on the quality of the counselor-adolescent relationship, humor can be used to help the adolescent change his or her attitude.

A negative attitude is fairly common with adolescents who have just started treatment and are angry about being "forced" to participate in treatment, whether by parents, school, or the legal system. It is often futile to try and convince the adolescent that he or she needs to be in treatment. Empathizing with the adolescent will begin the process of developing a trusting and

caring relationship. A counselor's effectiveness is in large part a function of the counselor-adolescent relationship. A counselor must be patient. Despite all good intentions and desire to help the adolescent on the counselor's part, change will occur when the adolescent decides to make changes, and not when the counselor pushes the adolescent to make changes. The counselor needs to convince the adolescent that they are working together in a collaborative relationship to accomplish the adolescent's goals. The adolescent's sole goal may be to get out of treatment and this goal provides an excellent platform from which to work. The counselor can suggest that attending groups, leaving clean urine screens, not getting any school detentions and/or attending school, and not getting any more legal charges will help him or her reach the goal of getting out of treatment. Ultimately, completing treatment can help get the adolescent's parents and probation off his or her back. Counselors seek to work with the adolescent by working from his or her goals.

On occasion, an adolescent's negative attitude is destructive to the group. The adolescent's attitude and behaviors adversely affect other adolescents. Very often, the adolescent's counselor will meet individually with the adolescent and explain how his or her behavior is a problem: that it is okay to resist and fight the system, but it is not okay to drag others down with him or her. The adolescent may be reminded that CHS is a voluntary program and that treatment may not really be the right place for him or her at this time. The counselor may review group behavior rules and explain that when adolescents continue to break rules, they will be unsuccessfully discharged and possibly referred for residential substance abuse treatment or behavioral treatment. The adolescent needs to decide what is best for himself or herself (i.e., place the responsibility on the adolescent). Whenever possible, the counselor states that he or she believes the adolescent can make the necessary changes. The counselor should demonstrate faith in the adolescent's ability to make good decisions and to be able to control his or her behavior and attitude.

Adolescents' negative attitudes are sometimes a result of resentment. Blaming others for their self-induced problems is common. Adolescents will hold on to resentment (i.e., blaming, negative attitude) for long periods of time in order to avoid accepting responsibility for their actions. Adolescents are frequently resentful toward their parents and/or the legal system when they enter treatment. They view their being in treatment as their parents' or the legal system's fault since they "forced" them to enter treatment. Working through denial (i.e., blaming, not

taking responsibility for their behaviors, denying any relationship between their life problems and substance use) is a first step toward recovery. Resentfulness, honesty, acceptance, and responsibility are addressed in skills and counseling groups. Forgiving and/or forgetting resentment is often very difficult for an adolescent substance abuser. Counselors can try to help the adolescent assess the pros and cons of holding on to resentment, and counselors can model acceptance and forgiveness in counselor-adolescent and staff relationships.

Crises

The safety of both adolescents and staff is the overriding consideration when dealing with a crisis. Helping the adolescent through the crisis involves empathic listening, obtaining accurate information, and securing the safety of all parties involved in the incident. Counselors are told to contact the OP coordinator or another coordinator as soon as possible to consult and decide on a course of action. The entire incident, including all actions taken to help the adolescent, should be documented in the adolescent's historical file. Frequent follow-up, either hourly or daily, and documentation of the follow-up goes without saying. Above all, the adolescent needs someone to guide him or her through the crisis. When the crisis has passed, the counselor should help the adolescent process the incident on a less emotional level. In other words, the counselor can review the incident from a learning perspective with the goal of helping the adolescent avoid a similar crisis in the future.

The most common crises are suicidal ideation, aggressiveness/anger directed toward another adolescent, and reports of abuse (usually physical abuse). Suicidal ideation typically takes one of two directions: talking the adolescent through the crisis and completing a signed contract to not hurt himself or herself, or involving the community crisis team to talk with the adolescent to determine the need for hospitalization. Helping the adolescent identify social supports that he or she can access is an important intervention that can alleviate loneliness and feelings of alienation.

Historically, an aggressive adolescent will settle down relatively quickly if the counselor can separate the angry adolescent from the group and the person with whom he or she is angry. Adolescent substance abusers often have great difficulty letting go of their anger in the presence of their peers. Separating them allows them to "save face" and not to appear as if they backed down, at least in their perception of the situation. On occasion, an adolescent is gently persuaded

that it would be best for them not to return to groups and to go home. This allows for time to address the issue with all involved adolescents and to determine if it is necessary to separate the adolescents in the future. If an adolescent has had repeated anger management problems in the group setting, individual counseling may be substituted for group work. It may also be possible to arrange group schedules so that the two angry adolescents attend groups on different nights. Another strategy is to ask the two adolescents to meet with a counselor to discuss how they can avoid future outbursts. The latter approach may be framed in terms of how they can avoid being unsuccessfully discharged (i.e., gentle confrontation).

When an adolescent reports abuse, the counselor does not question the validity of the report, but listens carefully to the adolescent's story. Probably the most common type of report is a female adolescent reporting that a boyfriend hit or pushed her. It is rare that an adolescent will indicate that he or she feels it is unsafe to return to his or her home/environment. Counselors offer to help the adolescent make a police report and clearly state that abuse is against the law. They may discuss how the adolescent can avoid situations where abuse could again occur, the merits of the relationship, and the pros and cons of telling their parents about the abuse. When abuse from a family member (or someone living in the adolescent's home) is reported, it is explained to the adolescent that a counselor is required by law to report the abuse. Historically, few adolescents have followed through when a counselor has offered assistance to be placed in an alternative environment. Counselors seek to impress upon the adolescent the seriousness of the situation and may solicit a promise from the adolescent to report any further abuse. The counselor also talks with the adolescent about his or her feelings related to involving the alleged abuser in a family session. Adolescents most frequently ask that the counselor refrain from discussing the issue of abuse with their families. This request can be honored and family sessions still scheduled. However, the adolescent is strongly encouraged to talk about the incident with family members with whom they feel safe.

Counseling involves helping the adolescent see that no one ever deserves to be physically, sexually, or emotionally abused; that abuse is against the law and they are protected by the law. Assessing the adolescent's feelings toward the abuser often reveals conflicting feelings. Helping the adolescent make sense of these feelings (i.e., identifying and normalizing the feelings) may lead to decisions about re-defining or terminating the relationship.

Empowering the adolescent as well as supporting him or her are keys to fostering positive changes in the life of an adolescent.

Treating Co-Occurring Disorders

Co-occurring disorders are common among adolescent substance abusers (Dennis et al., 1999). Often an adolescent is initially (on assessment) diagnosed with one, two, or even three "rule out" diagnoses. It is quite common for an adolescent and/or the family member(s) to endorse symptoms of ADHD, conduct disorder, a mood disorder, and/or anxiety. Substance disorder symptoms can mimic symptoms of these disorders. Thus, it is logical to observe the adolescent's drug-free behaviors in order to determine if there truly is a co-occurring disorder. An appropriate MTP goal would be to monitor the adolescent for symptoms of the respective diagnoses. If the symptoms persist after several weeks of abstinence, the adolescent could be referred to the psychiatrist.

Most adolescents and their guardians will comply with a psychiatric referral recommendation. However, in spite of providing education about psychiatry and medications, some adolescents and/or their guardians refuse to follow through. In some cases, it is possible to involve school officials when the adolescent is exhibiting symptoms in that setting (e.g., ADHD symptoms of inattentiveness, or behavioral problems suggesting conduct disorder or oppositional defiant disorder). It should be noted that adolescents who are depressed often exhibit irritability, anger, and are easily frustrated. Behavior problems can be symptomatic of a mood or other disorder. School officials can also try to help the family see that a psychiatric referral is in the adolescent's/student's best interest.

With continued resistance from the family, the counselor can only work with the adolescent and family to identify the specific behaviors that need to change in order for him or her to accomplish the respective MTP goals. Examples include no detentions at school, earning scores in OP groups that indicate compliance with rules and appropriate involvement in group discussions, a decrease in sleep problems, maintaining employment, developing a more trusting and less problematic relationship with parents, and following house rules and completing assigned chores at home. Many skills groups directly address how to change and maintain these types of new behaviors. Individual and family counseling are also utilized to address these

issues. Parents are educated that they can help change maladaptive behavior by providing structure and consistency, as well as support and encouragement.

When an adolescent is prescribed psychiatric medication, it is imperative that the adolescent and family understand the importance of taking the medication exactly as prescribed, possible side effects, and the symptoms that the medication can relieve. The counselor should present this information in a realistic yet optimistic manner since the effectiveness of medication can be affected by the adolescent's attitude toward it. In other words, medication expectations have a very real effect on the successful or unsuccessful alleviation of symptoms. Both the family and adolescent need to be told that virtually all medications are not effective when illegal substances are used. Another frequent issue that surfaces with medications is the unrealistic expectation that symptoms will immediately disappear. Helping the adolescent and family to be patient and to give the medication a chance to work (typically two to four weeks) should also be discussed.

Counselors need to regularly check in with the adolescent and family members about any positive changes and/or side effects related to medication. Sensitizing others, including other OP staff, to be aware of small changes helps increase compliance through the giving of positive feedback about changes in behavior. Adolescents often do not see or feel any effect of the medication, at least initially. Identifying the changes for them is an effective way for the counselor to increase compliance and demonstrate their concern and caring for the adolescent.

While certain comorbid disorders will need to be treated with medication, not all will. For example, conduct disorder, a relatively common co-occurring disorder, is not *directly* treated with medication. Conduct disorder symptoms are sometimes relieved when medication is prescribed for another psychiatric disorder such as ADHD or major depressive disorder. Conduct disorder symptoms are addressed through other interventions including individual and group counseling and various skills groups. MTP goals explicitly identify related problem areas and the specific interventions aimed at decreasing associated life problems.

XI. Transfer and Discharge Process

An adolescent's movement between levels of care (transfer) or discharge from treatment is a treatment team decision. Staff meetings are used to discuss adolescent progress or lack thereof. When staff members believe that an adolescent will be better served in a different level of care, he or she is transferred to that level of care. Progress attaining MTP objectives could result in transfer to a less intensive level of care. Lack of progress on MTP objectives could result in transfer to a more intensive level of care. Both lack of progress on MTP goals and completion of MTP goals could result in discharge (i.e., unsuccessful or successful discharge).

Counselors use ASAM criteria, the progress made on MTP goals, and information from collaterals to determine the appropriate level of care for an adolescent. They are expected and trained to be thoroughly knowledgeable about ASAM criteria. However, since the MTP's development and design is based on the six ASAM dimensions, progress on these goals/objectives serves as the primary source in determining the appropriate level of care. Likewise, collateral information serves to evaluate the progress made on specific MTP goals (e.g., meeting regularly with a probation officer, attending school regularly, maintaining part-time employment, completing chores at home, not lying/being honest).

Determining Readiness for Transfer and Discharge

The CHS model uses the treatment team to make transfer and discharge decisions because team based decisions (versus individual decisions) help ensure a higher degree of objectivity. For example, a counselor may become frustrated with a particular adolescent's behavior and tend to be punitive. It is also possible that a counselor would enable certain adolescents by trying to rescue them or protect them from logical consequences of their behavior. Group decisions are a safeguard against inconsistency and viewing the adolescent through rose-colored glasses. In addition, feedback from other staff members about an adolescent can be illuminating and help make the primary counselor aware of certain aspects of the adolescent's treatment progress. Adolescents sometimes behave differently when their primary counselor is not present (generally less compliant). It is also possible that an adolescent may participate at a much higher level in certain groups. During discussions about transfer and discharge, a question frequently asked is, "What is in the adolescent's best interest?" A major

task of the OP coordinator is to remind the counselors and demonstrate through personal example that decisions are based on best clinical practices and that each adolescent is deserving of the best possible care. The justification for any action taken by the treatment team should be clear and in the best interest of the adolescent.

Transferring an Adolescent Due to Progress or Lack of Progress

The most common type of transfer due to progress on MTP goals is from IOP to OP. The next most common type of transfer is from residential treatment to OP/aftercare. These adolescents typically have demonstrated all of the following to some degree: emotional and behavioral stability (ASAM III), an increase in motivation to stop using (ASAM IV), a decreased relapse potential (ASAM V), and the development of a supportive recovery environment (ASAM VI). Transferring an adolescent from IOP to OP often is dependent on a significant decrease in urine screen drug levels or on a clean screen. Other significant variables that are weighed in this decision are treatment group attendance, the level and content of group participation, and the adolescent's stability in the community (i.e., home, school, job, no additional legal problems). Often, adolescents are just beginning to develop their supportive recovery environment at the time of transfer.

Adolescents who transfer from a residential treatment program after successfully completing residential treatment are labeled as "aftercare" adolescents. Aftercare adolescents generally have demonstrated long-term emotional and behavior stability, have demonstrated long-term (i.e., at least several months) sobriety, have developed or have a good start on developing a supportive recovery environment, and have a personal commitment to changing their lives and pursuing healthy goals. Wednesday evening treatment groups are designed for this type of adolescent. They tend to be in OP for two to four months and usually attend groups or individual sessions every other week during their last month of treatment. This gradual withdrawal of treatment is an attempt to slowly accustom the adolescent to a lifestyle without the support of treatment.

If the adolescent is not progressing through his or her IOP or OP treatment, a recommendation for transfer to residential treatment may be made.

Discharging an Adolescent Due to Progress or Lack of Progress

Discharging an adolescent due to progress on MTP goals (i.e., an As Planned discharge status) is determined in a staff meeting on or shortly before the date of discharge. The counselor reviews the adolescent's behaviors and attitudes. He or she also reviews the observations and feelings of parents, probation, and other collaterals about the adolescent's discharge. The adolescent's continuing care plan (i.e., support systems and activities that will help the adolescent maintain sobriety) is described. The adolescent typically knows when he or she will likely be discharged. Counselors give the adolescent the date of his or her probable discharge two to four weeks prior to the projected date to help motivate the adolescent to maintain his or her progress and work on MTP goals.

The most common reason adolescents are discharged due to lack of progress is because they fail to attend their scheduled groups and/or individual sessions [i.e., Against Staff Advice (ASA) discharge status]. Once or twice a year, an adolescent is discharged due to severe behavioral and/or emotional instability [i.e., At Staff Request (ASR) discharge status]. Prior to both types of discharges, a variety of interventions are implemented in attempts to re-engage the adolescent in treatment. These might include telephone calls to collaterals and the adolescent to determine the problem, scheduling family sessions and/or meetings with collaterals such as probation, and sending letters explaining that the adolescent will be unsuccessfully discharged if CHS does not hear from him or her by a certain date. If the adolescent has been consistently disruptive in groups or otherwise not profiting from groups, the counselor may remove the adolescent from groups and schedule individual sessions. Sometimes the adolescent successfully finishes treatment while only attending individual sessions. At other times, the adolescent is moved back into groups after the behavior has stabilized.

When an adolescent is unsuccessfully discharged, the final staff discussion helps generate recommendations that will be provided to the adolescent and family. A common recommendation is for the adolescent to be re-evaluated for the appropriate level of care of substance abuse treatment when he or she is amenable, or if the adolescent is willing to transfer to residential treatment. The counselor completes a Discharge Summary report that details the adolescent's progress and difficulties while in treatment and details recommendations. These reports are mailed to collaterals. It is quite common to later re-admit unsuccessfully discharged adolescents after they have appeared in court or after they have incurred additional substance-

related life problems. When an adolescent is re-admitted, a priority is to assign the adolescent to his or her original counselor. It is only on rare occasions that an adolescent will request a different counselor.

Discharge Planning

Discharge planning begins early in an adolescent's treatment. Family counseling is an intervention that can have a significant effect on an adolescent's success after leaving treatment and is strongly encouraged. Helping parents learn how they can be supportive, how they can be "good" parents, and how they can redevelop trust can help the adolescent return to an environment that is recovery-oriented, structured, and consistent in reinforcing positive behaviors and providing consequences for negative behaviors.

During treatment, adolescents attend groups that focus on the development of a supportive recovery environment. Issues discussed in these groups include family relationships, peer relationships, recreation/leisure activities, school and job responsibilities, maintaining a structured lifestyle, utilizing AA/NA/CA meetings and a sponsor, dealing with feelings such as anger and boredom, avoiding illegal activities, and following through with any recommendations for services such as psychiatric medication management or medical problems. Adolescents also complete a poster that identifies their personal relapse triggers, what they can do to avoid using in those situations, their support network, and what has helped them maintain sobriety while in treatment.

Successful Discharge Party and the Final Family Session

When an adolescent is successfully discharged, two events are planned. First, about ten to fifteen minutes of group time is devoted to a good-bye party. Second, the counselor schedules a family session that either precedes or follows the good-bye party.

During the time taken from a group, the counselor talks to the group about the positive changes that they have observed in the adolescent while he or she has been in treatment. The person being discharged is then encouraged to talk about his or her treatment experience and plans for the future. Other adolescents are provided the opportunity to say good-bye and discuss any positive changes they have seen in the adolescent being discharged. The counselor then presents the adolescent with a certificate that indicates they were successfully discharged from

treatment, a book that is either an AA/NA publication or a meditation book, and a CHS key. The key is a brass blank key that has the CHS logo and telephone number on it. The key is presented as a symbol of the adolescent's success and positive changes while in treatment. Then everyone shares either cookies or cake that is provided by the counselor.

The goals of the family session include completing discharge paperwork, reviewing the adolescent's and family's positive changes as evidenced in the completion of MTP goals, discussing what to do if a relapse occurs, and reviewing the adolescent's continuing care plan. On the adolescent's last day of treatment, counselors focus on the positive and do not dwell on the problems the adolescent experienced while in treatment. When discussing the continuing care plan, it is appropriate to identify the adolescent's relapse triggers. The adolescent can explain how the family can help him or her cope with relapse triggers and how they can generally support his or her recovery process. Often the counselor will facilitate a discussion between the parents and adolescent to identify specific behaviors that would increase trust and allow the adolescent to earn back additional freedom (e.g., later curfew, use of the car, spending time with friends).

Most counselors complete the discharge paperwork at the beginning of the family session. The paperwork includes reviewing the MTP goals. Thus "family counseling" occurs simultaneously with the completion of paperwork. The adolescent and family sign a discharge form that outlines the adolescent's continuing care plan. If there are referrals to other agencies (e.g., for medication management or medical issues), the counselor is expected to stress the importance of the adolescent and family following through with the recommendation(s). Reviewing the adolescent's social supports helps the adolescent and family not feel alone or isolated as the adolescent leaves treatment. If they have questions or concerns in the future, the adolescent and family members are encouraged to contact the counselor at any time. The counselor is expected to balance the optimism of successful discharge with a realistic understanding of the probable difficulties that families often face at this stage of the adolescent's recovery process.

XII. Staff Characteristics and Requirements

The outpatient program currently includes a coordinator, three full-time counselors (also called primary counselors), the Latino youth interventionist, and a part-time outpatient counselor assistant. While case managers are not technically part of the outpatient program, they work very closely with it. Outpatient staff may also work with medical staff, although the medical personnel spend most of their time with residential adolescents. Another group that plays a critical role in providing comprehensive and professional services is the support staff. This section describes the basic job duties and requirements for all staff positions. Appendix B includes the job descriptions for the key staff.

CHS has found that the ability to work with this population requires certain characteristics beyond education and experience. Evaluating whether or not a potential applicant has the necessary characteristics is an important part of the hiring process. A critical characteristic is the desire to work with the adolescent population. A person also needs a high level of patience, an ability to be consistent and supportive of the program's structure (i.e., philosophy and rules), and an ability to work as a team player. While direct experience with adolescents is preferred, it is not a requirement. The previous characteristics are expressly noted as requirements of working in the outpatient program during the hiring process. Staff members may be in recovery, but this is not a primary consideration when hiring staff. If a job candidate discloses that he or she is in recovery, the candidate is told that CHS prefers that a potential staff member have at least two years of sobriety.

Currently, all staff members who provide direct services to adolescents are either licensed (e.g., LCPC or LCSW) or certified (CADC), or working towards licensure or certification. All staff members are required to obtain a license or certification by the end of their second year of employment.

All newly hired staff members are required to attend an all-day training that addresses CHS philosophy, the structure of the organization, the policies and procedures of CHS, confidentiality, safety procedures, and infection control/universal precautions. All staff attend trainings and seminars that satisfy the respective requirements of their license and/or certification. CHS covers the cost of trainings and continuing education units (CEUs). CHS is

fortunate to have a division, Lighthouse Institute, which provides trainings/CEUs to substance abuse counselors across the state.

Outpatient Coordinator

The current outpatient coordinator has a master of arts in counseling psychology, is a Licensed Clinical Professional Counselor (LCPC), and is a Certified Reciprocal Alcohol and Drug Counselor (CRADC). He has worked at CHS since 1988, first as a part-time residential counselor, then as a residential primary counselor, then as the outpatient coordinator since 1997. Familiarity with all treatment levels of care and an understanding of the unique needs of adolescent substance abusers is important for this position.

The coordinator supervises the primary counselors, the outpatient counselor assistant, and the Latino youth interventionist. The outpatient coordinator also supervised two case managers until late 2001. At that time, CHS services were expanded and an intake coordinator position was developed. The intake coordinator began supervising all case managers. All full-time positions receive an hour of individual supervision each week. The part-time positions receive a half-hour of supervision each week. However, the coordinator is available throughout each day for consultation.

The OP coordinator also maintains a relatively small caseload of adolescents, which has ranged in number from three to eight. He leads staff meetings twice a week, leads five skills and counseling groups each week, coordinates referrals to the OP program, attends management and quality improvement meetings, leads two of the Family Night programs, and reviews performance data on the program and all outpatient staff. The director of youth services has regular supervision meetings with the outpatient coordinator for an hour each week. A relatively small percent of this time is spent reviewing cases. Instead, most of the supervision hour is used for reviewing counselor and general program issues.

Primary Counselors

A full-time primary counselor is expected to maintain a caseload of around 20 adolescents and deliver 20 to 25 hours of billable services a week. Counselors are responsible for reviewing assessment reports; confirming diagnoses; making treatment recommendations; admitting adolescents; developing individualized MTPs; providing individual, group, and family

counseling; leading five skills and counseling groups per week; and maintaining weekly contact with each adolescent's collaterals. They are also expected to maintain records of all services provided; attend and participate in all staff meetings; write assessment, transfer, and discharge reports; and develop a continuing care plan with each adolescent that is discharged.

Counselors are encouraged to provide as much individual and family counseling as their schedules will allow. The 20 to 25 hours of billable services include individual, group, and family counseling; leading skills groups; written, telephone, and face-to-face contacts with collaterals; completing assessments; and the development of MTPs. During weekly supervision, the coordinator reviews with each counselor management information system reports based on the previous week's billable and non-billable services. This review provides relatively quick feedback about the services provided and often leads to discussions about time management, difficulties in engaging families, and/or how the counselor was able to achieve the goal of providing 20 to 25 hours of billable services.

Latino Youth Interventionist

The Latino youth interventionist (LYI) is a relatively new position in the CHS adolescent OP program. In 1999, an individual was hired to begin developing a Latino outreach program. While most of the outreach activities occur in McLean County, several schools and providers outside of McLean County receive Latino outreach services. A requirement for this position is that the person is bilingual in Spanish and English.

This individual is responsible for ensuring that Latino youth have access to substance abuse treatment services. He provides outreach services for individuals, families, and community agencies including schools, churches, treatment facilities, probation departments, and recreation centers. His goal is to provide assistance that eliminates barriers that make it difficult or impossible for Latinos to access treatment services. Other job responsibilities include networking with community agencies that can function as support systems for Latino youth, developing supportive relationships with Latino CHS adolescents in all levels of care, completing assessments with Latinos, providing post-treatment support for Latino adolescents who are discharged, making presentations to community organizations about treatment or the prevention of substance abuse problems, leading OP skills groups, and providing interpretation services. For example, the LYI is available to assist Spanish-speaking parents in court.

The LYI has assembled a library of videos, books, treatment materials, and information for parents that speak directly to Latinos. Most of the materials are presented in Spanish. While most Latino adolescents have some skills in English, a significant number of their parents have difficulty understanding English. Latino adolescents may also experience language barriers, and several of the adolescents the LYI has worked with attend English as a Second Language (ESL) classes in the local schools. The LYI helps them address cultural and self-esteem/self-image issues and access various community services and drug education.

Outpatient Counselor Assistant

The counselor assistant position is part-time (15 to 20 hours per week). A major duty of the counselor assistant is to attend nearly all skills and counseling groups each week. This position is entry-level, typically held by a college student, and provides an opportunity to learn about adolescence and substance abuse, lead groups, and develop an understanding of counseling and the treatment process. Although the counselor assistant is not required to act as a co-leader and help facilitate in most of these groups, he or she is encouraged to participate as a leader when comfortable doing so. Currently, the counselor assistant leads the Drug Education skills group. Other job duties include transporting adolescents to and from OP groups, assisting adolescents with leaving urine screens, completing a variety of paperwork, and monitoring adolescents before, during, between, and after groups.

The primary counselors are expected to empower the counselor assistant, because he or she is with adolescents more often than any other staff member. The adolescents need to respect and comply with the counselor assistant's requests. Empowering the counselor assistant is facilitated by introducing him or her to the adolescents as a counselor and encouraging him or her to participate as a co-leader in groups, to require adolescents to follow rules and to give consequences when rules are broken, and to spend individual time with adolescents whenever possible in order to develop trusting and caring relationships.

Case Manager

Case managers complete initial screenings and comprehensive assessments and set up admissions. They also develop community resources and meet with major providers in order to explain CHS services and to ensure that the referral process is timely, efficient, and meets the

needs of adolescents and their families. One case manager works very closely with the OP staff. This case manager provides services to adolescents in McLean County, where almost all OP and IOP adolescents live.

The case manager maintains an appointment book with weekly admission times for all OP counselors. After completing an assessment and staffing the case, the case manager attempts to set up an admission appointment while the adolescent and his or her family are still at CHS. If the available appointment times do not work for the adolescent and family, they are told that a counselor will contact them the following day to set up the appointment. Local evaluation data have shown that the sooner an adolescent is scheduled for an admission appointment following the assessment, the more likely it is that the adolescent will follow through. If more than two weeks pass after the assessment without the adolescent being admitted, the chance that they will be admitted dramatically drops. This is true for both adolescents who are court-ordered to treatment and those who are not.

The case manager regularly meets with counselors to review adolescent assessment information. Biopsychosocial assessment reports are forwarded to the respective counselor very quickly—typically from two to four days after the assessment. Thus, the counselor has both the GAIN-I (assessment instrument) and the assessment report with which to work. The admission appointment is treated as a family session. The adolescent and family are asked about treatment goals they would like to address. Information from the GAIN-I identifies many appropriate treatment goals and can be reviewed during the admission/family session. The case manager's ability to quickly write reports and review the GAIN-I for completeness and accuracy is very helpful and much appreciated by the counselors. When the report is completed prior to the first treatment session, it allows for treatment to begin in that first session rather than using it only to explain the program and complete admission paperwork. Currently, the program is moving toward using a computer-based interactive GAIN-I that will produce a draft narrative report that can then be edited and finalized by the case manager. This approach to producing the report should save additional staff time.

Working closely with the case management program results in a more informed and efficient treatment team. Toward this end, a case manager attends an OP staff meeting each week. During this meeting, the coordinator informs case managers which counselors can take new adolescents. Also, updates are provided about scheduled and rescheduled admits. Case

managers can often provide insight into how best to contact an adolescent or the family, and this information helps counselors move more quickly in setting up admission appointments.

Medical Staff

Medical staff members include a physician, several nurses, and a child and adolescent psychiatrist. The physician and psychiatrist are at CHS for two half-days each week. A nurse is at CHS for approximately 12 hours each day. The physician and nurses spend relatively little time with OP or IOP adolescents, but they are available for these adolescents when needed. Most of their work occurs with residential adolescents. IOP adolescents received nursing assessments until late 2001. At that time, the procedure was changed and the counselor began completing a physical assessment during the admission process. The primary counselor, using an approved protocol, determines if it is appropriate to refer the adolescent for a physical examination by a physician.

The psychiatrist is available to provide services for OP and IOP adolescents on a weekly basis. The psychiatrist may provide a psychiatric evaluation or provide ongoing medication monitoring. After the service, the psychiatrist writes a report that is provided to the adolescent's counselor. Primary counselors frequently consult with the psychiatrist in order to better understand how they can support the psychiatrist's recommendations and address psychiatric issues with particular adolescents. The psychiatrist continues to meet with adolescents throughout their treatment experiences for medication management and to either rule in or rule out psychiatric diagnoses. When an adolescent with psychiatric follow-up is successfully discharged, a referral is made to a physician or psychiatrist in the community.

The primary counselor can play an important role in the adolescent's and family's level of compliance concerning psychiatric recommendations. Adolescents very often need monitoring and encouragement to take their medication as prescribed. The primary counselor regularly assesses for compliance and side effects of medication. This information, along with the counselor's observations of the adolescent's behaviors, is shared with the psychiatrist.

Support Staff

Support staff are often an unsung, but critical, component of the OP program. Support staff members include receptionists, word processing clerks, the adolescent account group,

records clerks, quality improvement staff, and management information systems staff. Each support group plays a role in providing and improving the quality of services to adolescents and their families. At CHS, the coordinator and all OP staff regularly have contact with all of the various support staff.

Receptionists

Since first impressions are clearly a factor in someone's perception of an organization, the receptionists are trained to be consumer-friendly and to be caring, understanding, and patient in all contacts with the public. The receptionists are made aware of appointments so that they can be as expeditious as possible.

Word Processing Clerks

Word processing clerks complete all types of reports, graphics design projects, and many other tasks that allow counselors to focus on counseling rather than spending time typing, making corrections, and printing reports. Primary counselors dictate MTPs, group notes, assessment reports, and discharge and transfer reports. The clerks produce and return the finished products to the counselors. CHS has a reputation for being professional and quality-oriented. The reports that are sent to other facilities and are entered in the adolescent's historical files look very professional. The appearance of the reports helps enhance Chestnut's reputation for professionalism. There is a movement toward automating more of this work with computers.

Client Accounts

Many parents have concerns about the financial aspect of placing their son or daughter in treatment. The client intake assistant is the person who speaks directly with the family and adolescent about their financial obligations (this begins the admission process). The client intake assistant frequently deals with distraught families who are at a loss about how they will pay for their son's or daughter's treatment. It is fortunate that CHS has state grant dollars available to provide financial assistance to many families. After the financial arrangements are worked out, the adolescent and family meet with the counselor and complete the admission process.

The client accounts group also includes employees who bill adolescents and their families, insurance companies, and the state of Illinois (for grant-eligible adolescents and Public

Aid adolescents) for all billable services. They often talk with family members to help them understand the charges for treatment services.

Records Clerk

The records clerk maintains the medical and historical files for past, present, and prospective adolescents. The counselors rely on the records clerk to provide reminders when reviews or documentation are due. Thus, the records clerk completes quality improvement functions to assure that documents (e.g., MTPs; assessment, discharge, and transfer reports; progress and group notes) are completed in a timely manner and/or are signed by the adolescent and appropriate staff. The orderliness of the records room and the standardization of the structure of adolescent files make it very easy for staff to locate any needed document.

Quality Improvement Staff

Quality improvement (QI) staff schedule monthly meetings with the adolescent program director, all adolescent program coordinators, nursing staff, and recreation staff to review data on performance indicators. Monthly statistical reports provide an in-depth profile of adolescent information by program, staff activities, staff documentation errors, medical errors, incident reports (e.g., a door left unlocked; substance use on the unit; an accident that resulted in injury to staff or an adolescent), and the results of adolescent satisfaction surveys. Yearly goals are reviewed each month. The QI team recommends action steps to address any problem areas and reviews relevant data at a later date to determine the effects of the action steps.

Another important task of the QI staff is to inform appropriate staff about any changes in state or federal regulations or CHS procedures. Reviews by governmental agencies and JCAHO have consistently found a high level of compliance with regulations and accreditation standards thanks to the QI staff's attention to these details. QI staff also oversee the updating of program manuals that provide an in-depth review of all aspects of each respective program. The manuals are useful in the training process for new staff members and provide reference information for all staff members.

Management Information Systems Staff

Computers and management information system (MIS) staff and software help OP staff members and the coordinator do better jobs. All OP staff members have a computer in their office. Staff have access to a CHS intranet as well as Internet services. E-mail is widely used to communicate within CHS across multiple facilities and with outside agencies. The OP coordinator is able to generate MIS system reports that provide data on each counselor and total program performance that are useful for individual supervision, staff meetings, and program management. Equally important, the MIS department is responsive to both individual and program needs for training and technical assistance.

XIII. Clinical Supervision

The Role and Importance of Supervision

The goals for CHS's clinical supervision procedures are to help each staff member grow professionally and to maintain highly qualified and mentally healthy staff members. The supervision process includes five primary components: (a) initial orientation and training in CHS procedures; (b) required individual weekly meetings between a staff member and his or her clinical supervisor; (c) informal consultations with a supervisor during the workday; (d) supervisor observation of counselors; and (e) staff meeting discussions. Individual supervision is such an important part of this process that the term "supervision" often is used by supervisors and counselors alike to refer to the individual weekly supervision session. If for some reason the supervisors or counselors cannot attend a regularly scheduled supervision session, they are expected to reschedule an alternative supervision time during the week. Full-time staff members are provided one hour of individual supervision, and part-time staff members are provided a half-hour of supervision each week.

Both the director of youth services, who supervises the OP coordinator, and the OP coordinator have completed training in the provision of clinical supervision. Several issues addressed at trainings include: the components (i.e., administrative, evaluative, clinical, and supportive) of clinical supervision; various models of supervision; teaching leadership through example/role modeling; and the content, methods, and interventions of supervision. The training also outlines how to offer various types of feedback to supervisees, how to deal with resistance to change, and how to assess one's supervision skills. While trainings/seminars on supervision are not frequently offered—at least in central Illinois—there have been one or two trainings each year. CEUs typically can be earned from these trainings.

The supervision process also helps staff work toward meeting agency requirements that all staff that provide direct services to adolescents must be either licensed (LCPC or LCSW) or certified (CADC) by the end of two years from their date of hire. All counselors are licensed. Maintaining a license or certification involves earning CEUs by attending training sessions and seminars on topics related to the fields of counseling and substance abuse. CHS covers most costs associated with earning CEUs to maintain a staff member's credentials. Supervisors review potential training opportunities with staff and help determine if the training could benefit

the counselor's job duties (i.e., further their professional development). If the staff member is in need of CEUs for license or certification, the coordinator seeks approval from the director of youth services to pay for the training.

Training New Staff Members

The OP coordinator is responsible for teaching the CHS philosophy and theories of counseling that define the core values and treatment approach. Within the first month or two of being hired, new staff members are required to complete reading and written assignments that address the basic job requirements, confidentiality, and grievance procedures. They review the CHS Policy and Procedure Handbook and the Outpatient Program Manual. The OP Manual is a comprehensive review of all aspects of the program and is used as a reference in the training process.

The coordinator also enlists other staff as trainers. For example, a counselor may review one of his or her MTPs and discuss how an MTP is individualized. New employees are required to complete interviews with OP and other selected staff members. They observe other counselors leading groups, dictating reports, reviewing MTPs with adolescents, interacting with adolescents and families, working with adolescent accounts and records clerks, and participating in staff meetings. The training process seeks to validate the team approach—that staff members work together and use each other's strengths. If the new employee does not have experience with substance abuse and/or adolescents, additional readings are assigned and these issues are discussed in individual supervision sessions.

Individual Supervision Sessions

Individual supervision is the most-used intervention in providing support and direction to staff. At the beginning of a counselor's employment, the first few supervision sessions address both supervisor and supervisee expectations. The supervisor explains that the overriding goal of supervision is to help the staff person provide the most effective services for adolescents and their families. The difference between supervision and individual counseling is also discussed. The supervisees are encouraged to discuss any issue—even personal—that might affect how they interact with adolescents. The focus of supervision is to address issues in the context of how they might interfere with work-related activities, and while discussions may touch on personal

issues, supervisors make clear that supervision is not the place for individual counseling. The supervisor may suggest that the supervisee seek counseling services.

Staff use supervision sessions in a variety of ways. During a staff person's first year of employment, the supervisor addresses a number of issues that tend to be resolved with experience. These issues include lack of understanding of the paperwork requirements, feelings of being overwhelmed by adolescent issues and/or job duties, unrealistic expectations about adolescent success, poor report writing, personal fears about not being good enough or not knowing enough to treat effectively adolescent substance abuse, and difficulty understanding the regulations and CHS policies that drive the treatment process. The supervisor often encourages the staff person to slow down and helps him or her on one issue at a time. Supervision is most helpful when issues are thoroughly addressed. If there are several pressing issues, additional supervision times need to be scheduled to help alleviate an employee's stress level. The supervisor also normalizes feelings that the new employee experiences and empathizes with him or her. The supervisor communicates understanding and optimism about the supervisee's ability to become competent and skilled at completing the many different tasks.

Emphasizing the team approach and encouraging the person to consult with other staff is also a helpful intervention. Staff members learn why all program staff must support one another in their approach with adolescents and their families and how a "united front" is both therapeutic and results in a more manageable program. An example would be stressing the importance of consistency and structure in all adolescent interactions. Supervision is a time to review the new employee's observations and experiences, and to explain the rationalizations for specific treatment interventions.

Helping staff grow as counselors often involves leading the staff person back to the basics of counseling: listening, caring, being honest and open, believing that the person can change (optimism), allowing the adolescent and family to be responsible for change, and having realistic goals and expectations. These same traits are the foundation of providing effective supervision. The supervisor's interactions hopefully teach the supervisee by example about effective communication and counseling skills.

Other common problems addressed in supervision include time management, the timeliness of paperwork completion, decreases in billable hours, complaints about CHS procedures (generally paperwork), and personal issues. As noted earlier, many problems can be

approached from a positive standpoint or solution-focused perspective. The supervisor asks the question, "What worked in the past when this was not a problem for you?" This is helpful with time management problems, paperwork issues, billable hours, and developing a plan addressing adolescent issues. Of course there may be new or additional factors that require more than just looking to past behaviors for direction. The supervisor needs to help the counselor develop a strategy to address the problem. The supervisor should foster a collaborative relationship, not one of power. A supervisor's empathy and active listening is sometimes all that a staff person needs. While there are times when the supervisor acts as a teacher, the program develops a solid team approach when the supervisor empowers staff members and looks to them for solutions to problems.

More experienced counselors tend to begin supervision with small talk, often of a personal nature. Next, they discuss individual adolescents and their progress. During staffings, counselors often reveal their feelings about the adolescent (e.g., frustration, anger at the adolescent or the adolescent's family, sorrow for the adolescent, pessimism or optimism about the adolescent's progress, fears about consequences such as jail or family-imposed consequences). The supervisor helps the counselor examine what they can and cannot control in the adolescent's life. Oftentimes the counselor takes responsibility for adolescent behaviors and moves into an enabling or parenting role. Reviewing what CHS interventions—not just the counselor's—have been tried and what can be implemented in the future helps the counselor be more objective and less enmeshed. Validating and understanding the counselor's feelings begins the review process. The supervisor can then help the counselor to understand how the feelings might adversely affect the relationship with the adolescent (e.g., loss of objectivity, enabling, lack of consistency).

Common Issues Addressed in Individual Supervision

How a supervisor addresses issues is dependent on the staff person's level of experience and time working in the program. This is related to the level of trust between the staff person and the supervisor. With time, a more open and trusting relationship develops in nearly all cases. Newer staff tend to seek specific answers to problems and bring concrete issues to supervision. They are more interested in techniques. Also, it usually takes about a year for a person to become familiar with and knowledgeable of the many state and federal regulations and CHS

policies and procedures. As a staff person matures and gains a year or two of experience, supervision tends to focus more on how the staff person's personality interacts with different adolescents and family members. The following sections provide more information about the most common supervisory issues.

Seeking direction on specific cases. The supervisor expects supervisees to come to supervision prepared to present adolescent cases (i.e., with any needed documents such as the MTP or urine screen results). If supervisees are unsure about the direction to take with a particular adolescent and/or family they also should have some ideas about possible treatment interventions. Reviewing cases and the counselor's reactions and feelings about adolescents and their families is by far the most common supervision activity. The supervisor sometimes needs to have new employees, as well as more experienced counselors, investigate their feelings related to specific adolescents, other staff members, and the program. This is often a new experience and they are unaware of how this can be related to negative feelings. The supervisor can help the staff person look at how his or her personality traits interact with the personalities of different adolescents. However, this is typically not pursued in-depth until later in the staff person's employment. When a supervisee begins to look at this type of issue, it often signals that the person has matured and is advancing in professional development.

Concerns about leading groups. Fears about leading groups is a common issue that is raised during supervision sessions. The supervisor often addresses issues of competence, dealing with behavioral problems, and developing realistic goals for group interventions. Maintaining structure and being consistent are stressed as therapeutic interventions out of which the specific group goals are defined. It is important that the supervisor identify how group interventions follow from the theoretical foundations of CHS. This gives a sense of direction and justification for the program's content and the prescribed interventions.

Changing counselor behavior. If a supervisor feels that a counselor needs to change his or her behaviors, the supervisor may confront the staff member. Confrontation most often occurs when the staff person has lost objectivity and is either enabling/protecting the adolescent or is avoiding confrontation with the adolescent or family. Confronting the counselor is often most effective when the supervisor can refer to a previous similar situation in which the staff person responded appropriately. The use of a concrete example makes it easier to clearly define expectations. The supervisor's attitude is one of optimism and support in helping the staff

person either learn from or make the necessary changes to a problematic situation. At times it is helpful to explain how the expectation relates to the CHS philosophy or follows from the theoretical foundations of CHS. There are times when a counselor will disagree with how to handle a situation. After listening and demonstrating an understanding of the counselor's position, the supervisor simply states how the situation must be handled and why. The supervisor strives to use and teach from the following dictum: "What is in the adolescent's best interest?" This mindset is a key expectation for staff behaviors and adolescent interventions and is appropriate for guiding all decisions, so that decisions are based on adolescent needs, not staff needs.

Informal Supervision

In order to encourage informal consultations during the workday, the coordinator will often leave his office door open to send the message to staff members that they are welcome to consult as needed. The most common informal consultations involve discussing next steps with adolescents. A counselor may have gained new information through a recent telephone call and want to discuss new treatment recommendations based on the new information. Occasionally a counselor will voice frustration and an "I don't know what to do" mentality regarding a specific adolescent. Empathy, encouragement, and reminders of what the counselor did in the past in similar situations often satisfy the supervisee's needs. The supervisor may review alternative interventions. The supervisor, implicitly and sometimes explicitly, needs to advocate for the adolescent and feel comfortable that the final decision is in the adolescent's best interest. Helping the counselor process feelings of frustration, sadness, or anger is a necessary first step in assisting the counselor in making ethical and therapeutic decisions. Another informal supervision topic involves personal issues such as family problems, illness, feeling overwhelmed by work, positive personal experiences, taking time off, and dealing with other staff members.

Supervisor Observation

The coordinator can gain very useful information about counselor attitudes and clinical skills by observing counselors before, between, and after treatment groups, and this observation is a common occurrence during the first few months after a staff member is hired. For this reason, the coordinator sets aside time in his schedule to devote to this task. Any concerns that

are raised through these observations can be addressed in individual supervision sessions. These observations may provide important opportunities to reinforce positive interactions/interventions by the counselor.

Staff Meetings

Staff meetings may address the same issues discussed in individual clinical supervision sessions. For example, staff members may discuss how to address an adolescent's negative group behaviors. Sooner or later, all counselors struggle with this issue and have to learn how to tailor the proposed interventions to the specific adolescent. It is helpful for other counselors to review what has worked with adolescents in the past, and these discussions can be a learning experience for all staff. It also allows for the more seasoned staff members to be leaders and offer their wisdom and expertise in the service of providing effective treatment. Sharing leadership skills is strongly encouraged; it helps promote a sense of pride in the program and increases the counselor's level of self-confidence.

Since the supervisor also carries a caseload, staff meetings also offer the opportunity for the supervisor to demonstrate problem-solving procedures to other staff members. The supervisor elicits feedback from others, discussion follows, and a group decision is made. The supervisor can also provide good modeling by asking the question, "What is in the adolescent's best interest?" Staff decisions can have profound effects on adolescents and need to be carefully weighed. Staff members are expected to be adolescent advocates. Difficulties can arise when a staff person either has grown to dislike or feel very frustrated by an adolescent, or the staff person enables the adolescent and attempts to soften the consequences of his/her actions. The supervisor can minimize these problems by eliciting feedback from other staff and by directly addressing the staff person's feelings about the adolescent. Making objective decisions can be furthered by helping staff to become more aware of their personal feelings toward the adolescent and the family. For example, going to jail might be in an adolescent's best interest, while in other cases, an adolescent might deserve another chance. CHS believes that team discussions help staff members make the best decisions for adolescents.

XIV. Staff Training

CHS believes that the professionalism and quality of services is partially maintained by requiring staff members to participate in continuing education throughout their employment. While participation in training does not guarantee the delivery of quality services, it provides the foundation to continually improve and refine clinical skills. The adolescent program director and the program coordinators continually monitor staff to ensure that each staff member's service delivery supports the CHS mission statement, theoretical foundations, federal and state guidelines, and the American Counseling Association's code of ethics. The cost of training staff throughout their employment is, for the most part, covered by CHS. After formal training programs are completed, staff members are asked to complete assessments that test the acquisition of new knowledge. Copies of all education diplomas, certifications, licenses, and documentation of trainings/seminars attended are maintained in each staff member's personnel file.

New Staff Member Training

There are some training activities that are required of all CHS employees, regardless of the program they work for or the position held. During a person's first month of employment, he or she is required to attend an eight-hour new employee training program. This program orients new employees to the organization, philosophy, safety issues, expectations of staff conduct, and various staff members and their roles. Since CHS has a large number of employees that are geographically dispersed, another goal of the orientation session is to help new employees feel welcome. In addition, the supervisor will discuss with each new employee the importance of his or her position and the role each plays in helping adolescents and their families.

A new staff person is required to complete additional training tasks during the first two to three months of employment. The supervisor assigns and reviews these tasks. Please see the "Training Tasks" document in Appendix B that identifies the multiple training expectations. The tasks include observing treatment interventions and staff meetings, interviewing staff, watching and reporting on training videos, and reading manuals including the New Employee Orientation Manual, Policy and Safety Manual, and the Youth Outpatient Manual. (Note that the first two manuals are not included in this document.) Staff members are also trained on paperwork

requirements and specific job requirements such as completing urine screens and driving CHS vehicles. Prior to any adolescent contact, all new staff are required to complete a TB skin test, which is available at the CHS nursing office. Finally, the staff person completes written assignments that demonstrate that the manuals have been reviewed. The documented completion of the Training Tasks is then placed in the employee's personnel file.

Carefully reading the manuals is strongly encouraged and monitored by the supervisor. As can be noted from a review of this volume, the Youth OP Manual is very comprehensive and explains all facets of the program. The coordinator spends extra time reviewing expectations regarding the completion of all types of paperwork with each new employee. The timeframes for completion of paperwork are clearly stated in the manual. This careful review can eliminate later problems with a staff person saying that he or she was unaware of timeframes (i.e., giving excuses for poor treatment delivery).

Appraising Staff and Determining Competency

Staff competencies are appraised at three months and at yearly intervals by supervisors. Please see the "CHS Clinical Competency Skills" document in Appendix B that identifies job expectations. The document titled, "Job Title: Youth Primary Counselor. Job Description for the 12 Job Responsibilities/Work Functions" is the tool used by supervisors to assess a counselor's competency in the required job functions. Both three-month and yearly evaluation competencies are identified on this document. The supervisor assesses competency through adolescent chart reviews (i.e., the medical record), observation at staff meetings and supervision, engagement in therapeutic activities, performance improvement data (e.g., peer reviews), and individual QI data related to how the person spends his or her time.

The supervisor completes the above-noted documents and reviews the information with the respective staff person during supervision. Both strengths and weaknesses are identified. The staff person is asked to identify three or four professional goals that he or she would like to improve in the coming year. The supervisor helps the person define the goals in an objective and obtainable format. These goals can then be reviewed throughout the year. Some examples are becoming more knowledgeable about family therapy or a specific psychiatric disorder, increasing the number of weekly hours devoted to individual and/or family therapy, increasing

participation at staff meetings, or reworking skills group topics to be more effective and interesting to the adolescents.

The same process of appraisal occurs with the coordinator. The director of youth services supervises coordinators. An additional evaluation tool used by the director is the "Counselor Evaluation of Supervisor" document (see Appendix B). Counselors that are supervised by the coordinator are asked to complete the document and return it to the director. The counselors identify both strengths and weaknesses of the coordinator and the quality of the professional relationship. Both the director and OP coordinator have completed a significant amount of training in the delivery of supervision.

Maintenance Training

Maintenance training can occur each week during the supervision hour, at staff retreats, or during staff meetings. Maintenance training is helping staff members to appraise regularly their delivery of treatment and make necessary changes that maintain the integrity of the program and the CHS philosophy. For example, if there is an increase in documentation errors, the records clerk may attend a staff meeting to review the errors and how to avoid them. Supervision provides opportunities to address any problems observed by the supervisor. This might involve reviewing staff performance expectations and brainstorming about how to address the issue (e.g., decreased empathy toward adolescents, animosity toward another staff member, feeling overwhelmed by the workload, time management, documentation errors).

A program's services are built around staff personalities, competencies, and feelings. Training staff involves identifying each person's strengths and then helping them use their strengths to contribute to the program's effectiveness. The supervisor regularly helps staff members examine the values they hold in the pursuit of helping others. CHS management staff members believe that a healthy program is only as healthy as its staff members—both their attitudes and behaviors. There are times when the pace is hectic and staff feel pulled in many directions. Adolescents and their families can be disappointing and frustrating, and seem to be hopelessly caught in the downward spiral of substance abuse and mental illness. Staff may feel disheartened and sometimes question their competencies. The supervisor sometimes acts as a coach and provides the staff with affirmations that they did what could be done and used all the skills available to them in trying to help someone. Maintenance training also helps counselors

learn to persevere when they get discouraged. Allowing staff to share their feelings is a first step in helping them move from discouragement to learning from an experience and letting it go. The supervisor's role is to demonstrate and share strength, hope, and knowledge about how to move forward in the interest of the greater program goals.

Professional Development, Licensure, and Certification

Training clinicians to be more knowledgeable and competent in performing their job duties demands a commitment of both time and money. CHS prioritizes the training of staff and provides the majority of finances needed for training and development. The Illinois Department of Human Services Office of Alcoholism and Substance Abuse Licensure 2060 Regulations have established the professional staff qualifications for any staff person providing direct clinical services. Professional staff must 1) hold a clinical certification as a Certified Alcohol and Drug Counselor from the Illinois Alcoholism and Other Drug Abuse Professional Certification Association; or 2) be a licensed professional counselor or licensed clinical professional counselor pursuant to the Professional Counselor and Clinical Professional Counselor Licensing Act [225 ILCS 107]; or 3) be a physician licensed to practice medicine in all its branches pursuant to the Medical Practice Act of 1987; or 4) be licensed as a psychologist pursuant to the Clinical Psychology Practice Act [225 ILCS 15]; or 5) be licensed as a social worker or clinical social worker pursuant to the Clinical Social Work and Social Work Practice Act [225 ILCS20].

Any new professional staff must meet the professional staff requirements within two years of date of employment, and they must work under direct verifiable supervision of an individual who has staff supervisory responsibility at the facility and meets the above requirements.

The State of Illinois Department of Professional Regulation grants clinical licenses. A state license requires at least a bachelor's degree for a licensed professional counselor and at least a master's degree for a licensed clinical professional counselor. The Illinois Alcoholism and Other Drug Abuse Professional Certification Association grants certification; it requires a high school diploma and documented experience in the substance abuse field as well as demonstrated competent knowledge of substance abuse issues by passing a standard test. The current program coordinator is licensed and certified (LCPC and CRADC). The counselors are licensed or working towards licensure (either LCPC or LCSW). The Latino youth interventionist

and case manager are certified (CADC). The OP counselor assistant is not currently certified. However, when OP counselor assistants have worked for over a year in the position, they began working on earning a certification.

Both licenses and certifications require CEUs to be maintained. CEUs are earned by attending trainings or seminars on topics that are related to providing substance abuse treatment services. Maintaining one's license or certification is a requirement of continued employment at CHS in order to maintain a highly skilled work force.

CHS is fortunate to have a research, training, and publishing division, the Lighthouse Institute. The institute provides trainings with CEUs throughout the state of Illinois. Annually, three or four of these trainings are scheduled in the same facility that houses adolescent services. A certain number of employees are allowed to attend them free of charge, and this benefits both the agency and employees who are required to earn CEUs. Additional funds are also available to reimburse employees for other professional trainings that are of interest to them.

In addition to the professional trainings that award CEUs, CHS frequently provides in-service training on a variety of clinical issues. CHS staff members with expertise on the respective issue or problem area provide the training. Past topics for in-service training sessions have included assessment procedures, the use of substance abuse and personality assessment instruments, gangs, the legal issues surrounding confidentiality and disclosure authorizations, how to hire and fire employees, cultural issues, and how to deal with aggressive adolescents. These training sessions may last from one to four hours. Organizations often have staff with valuable knowledge that can be shared for the benefit of others. The opportunity to train others helps build on the strengths of existing staff members.

Professional development also can be addressed in supervision sessions by reviewing adolescent treatment interventions; processing individual, group, and family sessions; role playing difficult scenarios; discussing journal articles; or investigating how a counselor's personality style affects relationships with adolescents. Professional development is not only about acquiring knowledge or new skills, but also about better understanding one's self and what one brings to each adolescent relationship. As counselors mature (usually after several years in the position), they often acknowledge that basic counseling skills are the most important variables in providing quality services. Chestnut supervisors believe that empathy, building trust, a genuine caring for the adolescent, providing hope, being consistent, and maintaining a

structured environment are all techniques that help promote and facilitate positive adolescent change. With experience, counselors generally become more proficient at objectively evaluating their interventions and can come up with alternatives that might better suit a particular adolescent. They also tend to grow more accepting of the team approach. This approach can be construed as spreading out the responsibility for adolescent change (which is not necessarily a problem), and it helps develop trust among staff members and the recognition that all are working toward the same goal of alleviating suffering.

As noted above, the OP coordinator provides the clinical supervision for counselors in the program. Clinical supervision and the day-to-day running of the program to assure that it is addressing the needs of the current adolescents are the more "person-centered" activities of being a coordinator. The coordinator also has to pay attention to long-term goals of the program including its continued financial viability. This role includes understanding the budgetary and revenue needs and the importance of the QI program. To accomplish this task, it is important for the coordinator to manage data. Program and individual staff data are available from multiple sources including QI reports, special research projects, and the organization's MIS. For example, the coordinator reviews and compares monthly data on the program's performance and each individual staff member's performance. The latter will be reviewed weekly with the staff member in supervision sessions. An example of feedback using activity data is a review of the number of hours spent completing individual and family counseling. These summary reports are generated from activity reports that are entered into the MIS and serve the dual purpose of generating billing as well as individual performance reports. Developing management skills and the ability to use data to manage staff members is an important job function for the program coordinator and, if needed, will be an area for further professional development.

XV. Implementing the CHS Program

This chapter focuses on providing additional details about the program that might be helpful for implementing it elsewhere. The topics addressed include a discussion of the budget and revenue sources, facility needs, program marketing, staffing issues that have not been previously discussed, QI activities, and scheduling of groups and other services offered by the program. Potential challenges are identified and remedies are suggested.

Budget and Revenue Sources

The costs of setting up or maintaining a similar program would vary based on the location and available revenue sources. The following information provides basic details about the program's budget and revenues as a starting point. About 78% of the approximately $500,000 budget is allocated for personnel salaries and benefits. CHS has attempted to diversify revenue sources over the years, and the breakdown by revenue source differs for OP, IOP, and residential treatment. For example, Medicaid reimbursement accounts for a much larger percentage of revenue for residential treatment than it does for outpatient treatment. As is evident from Table 3, Chestnut's funding of adolescent OP and IOP services depends heavily on the state of Illinois system, which is built upon a two-pronged model. Rates for outpatient services are established on a uniform basis for all statewide providers. These rate methodologies were built in the 1980's and have not been updated in several years, so they rely on some outdated assumptions. The rate structure is minimalist in nature and does not include any enhanced services such as in-home continuing care and community and special service education. State funding is also limited. The global funding mechanism that is used by the state of Illinois provides a pre-determined dollar amount for the entire continuum of treatment services provided by a treatment organization. Once that global cap is reached, any further services provided are not reimbursed. The state does have certain set-aside funding for select special populations, and adolescents are one of these populations.

Table 3. CHS Bloomington OP/IOP Program Projected Revenue Sources (2003)

Revenue Source	OP	IOP	Total
Private Insurance	15.1%	56.5%	20.3%
Medicaid	6.8%	18.3%	8.3%
State Grant	51.7%	14.8%	47.0%
Client Fees	4.6%	5.3%	4.7%
Local Grant (School District)	3.9%	4.5%	4.0%
County Grant	17.5%	0.0%	15.3%
Miscellaneous Income	0.4%	0.6%	0.4%
Total	100.0%	100.0%	100.0%

Table 3 shows the percentage of revenue by each type of revenue source projected for fiscal year 2003. It is important to note that these percentages will vary from year to year based on a number of factors.

Facility Needs

The adolescent outpatient treatment program primarily operates in the late afternoon/early evening hours to accommodate adolescents who are attending traditional school. The current facility accommodates space for group sessions and office space for individual and family sessions for a four-hour block of time (3 p.m. to 7 p.m.). At a minimum, two group rooms with a capacity of 15 are in use. Additionally, a large room for the Family Night program and an area to provide child-care are used when necessary. Each therapist has his or her own office to conduct individual and family sessions.

The facility has a full-sized gymnasium and another large room that can be used for recreation. There is also a large outdoor green space for organized activities in the warmer months. The program provides a driver and a van for transportation on a limited basis.

Marketing the Program

Program marketing is a continuing process and uses multiple approaches. Chestnut has a marketing communications coordinator that helps the entire organization in these efforts. The adolescent program uses several approaches and targets multiple audiences including parents, school personnel, health care workers including doctors and nurses, social service organizations,

private counselors, child welfare agencies, faith community, civic groups, and the legal system. Over the years, Chestnut has developed a good relationship with the local media. It is common for reporters and other media personnel (e.g., radio, local TV station) to call Chestnut when stories require an expert opinion. Chestnut often provides informational booths at health fairs, professional meetings, and conferences. Brochures or other written materials related to the interests of the attendees are included, as well as small giveaway items that have the agency name, address, and phone number such as pens, pencils, stress balls, and key chains.

Another area that helps with marketing efforts at the same time that it promotes quality services is involvement in community organizations/groups that work with youth. The relationships developed with other children's agencies during these meetings help enhance service collaboration and coordination. Program staff are also involved with state organizations related to youth services.

Participation in special research and evaluation projects funded by the Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment and the National Institutes of Health has helped the program gather outcome data that can be used in presentations and material distributed to parents, youth, and the general public. The staff also facilitates focus groups with youth and parents to gather information about how well the program is meeting consumer needs and suggestions for improvement.

Staff members are made available to do community presentations on a variety of adolescent issues to different groups. Chestnut has a detailed web page that discusses available programs and provides other information about substance use. The following are descriptions of materials that are distributed to different groups.

- A parent packet that contains information regarding adolescent substance use, signs and symptoms to look for, actions they can take, and a description of Chestnut services provided and contact information.
- An informational packet targeted at professionals (i.e., probation officers, school personnel, health care workers, etc.).
- A general informational packet for distribution to civic groups and the faith community.

- Brochures for the general public that describe the Chestnut organization and specific adolescent services; these are placed in the agency waiting room and are sent to individuals or groups requesting information about the agency and programs.
- A non-confrontational brochure for adolescents that is designed to prompt them to think about substance use and potential consequences. Excerpts written by youth who have been in treatment are included, as well as contact information and a statement about confidentiality.

Staff

Successfully implementing the treatment program is dependent on choosing the right staff members and providing ongoing supervision and training. Chapters 12-15 in this manual address different aspects related to staffing including requirements, the clinical supervision process, and expectations regarding staff training. The adolescent program has strived to put together a diverse staff team (age, race, educational backgrounds, and life experiences). There are a number of characteristics that are desirable in choosing staff members, and they include:

- Genuinely likes adolescents and can connect with them
- Likes working with a diverse group of parents or caretakers
- Has a strong understanding of adolescent development
- Has a strong understanding of adolescent substance use and mental health conditions and how the two interact with one another
- Has strong communication skills with the ability to form strong relationships with others involved in the adolescent's life (e.g., probation officer)
- Is optimistic (e.g., believes change can occur), flexible, and able to avoid power struggles
- Is committed to professional development
- Recognizes the importance of QI activities and record-keeping expectations
- Accepts the need for program evaluation and is willing to be an active participant in outcome studies
- Has knowledge of community resources
- Understands the theoretical foundation of the program and is committed to following it.

Staff Meetings

Chestnut's program fosters the team approach through two staff meetings per week: one at the beginning and one in the middle of the week. All staff members delivering services to OP youth attend these meetings. Individual cases are staffed during this time. Since not all therapists are in each counseling group, this gives everyone the opportunity to talk about each group and the youth in attendance. The staff discusses what is working, what is not, who is doing well, and who is struggling. Staff meetings are also the place where program planning, review of procedures, and training take place. A supervisor or senior staff member leads these meetings.

Scheduling

Scheduling is one of the most challenging aspects of implementing the program. Adolescents and their parents are often unable to attend treatment early in the day; therefore, most activities take place between 3 p.m. and 8 p.m. The program staff are creative in managing their time to allow for admission appointments, individual sessions, family sessions, and group facilitation. To assist them in this task, each therapist is assigned to a number of groups. There are often two groups running simultaneously; therefore, Chestnut has two staff members available for each group time.

Typically, staff will have two to three slots for admission appointments in a week. The outpatient counselor assistant provides transportation from 2:30 pm to 7:30 pm Monday through Thursday. Childcare is provided during the Family Night program.

Setting Program Goals

The Chestnut OP team holds an annual all-day retreat away from the facility. The focus of the retreat is to review the previous year and plan for the subsequent one. Initially, the team identifies what has worked and what has not during the previous year. It reviews the curriculum, group topics, format, and schedules. Time is also devoted to reviewing management statistics, which include the overall number of clients treated throughout the year, the number of clients completing the program or transferring to another level of care, the number of clients who left against staff advice (ASA), the number who left at staff request (ASR), and staff time devoted to specific activities like direct services and paperwork activities. Once this process is completed,

the staff recommends program changes and develops goals consistent with the agency's mission and vision statement for the next year. Examples of goals that the OP program has established include meeting the census projections (i.e., 100 groups hours per week), improving client retention, and shortening the time from the treatment recommendation to admission into treatment. All program staff have a voice in this process to increase ownership of the program.

Importance of Quality Improvement Activities

The QI team helps continually to improve the treatment program. This team focuses on all programs within youth services (i.e., intake, case management, early intervention, OP and residential programs). Representatives from each program component attend meetings with the QI coordinator, medical staff, records staff, and recreation staff. The adolescent program has partnered with the research division on several projects, so a representative from the division also attends meetings. Since research staff bring expertise in program evaluation, they have been able to help the team develop goals with strong operational definition and meaningful outcomes.

One measure that the adolescent program has been tracking through its QI process is staff use of time. Each staff member has a daily log where he or she records codes for all his or her activities, such as direct service; time spent working with a client, family, or other collaborative (e.g., probation officer); and indirect services (e.g., paperwork, attending meetings). Summary reports generated from these data are reviewed. One sample expectation is that intake/case management staff will provide a minimum of 25 direct service hours per week. At the monthly QI meeting, the team reviews monthly reports to assess how well staff are meeting their projection. Comparison of data from different staff members may reveal problems. Once a problem is identified, a corrective action plan is developed and then monitored for a pre-determined time. Often, staff performance can be improved by helping them improve their time management skills.

Challenges for Replication/Barriers to Service

There are many challenges and barriers in today's behavioral health care environment to providing quality programs that are both cost effective and outcome based. The purpose of this section is to provide some ideas for addressing the barriers that might exist for implementing the treatment model presented in this manual.

This model requires that adolescents usually attend treatment sessions two or more times each week. If a program is located in the middle of a fairly populated community, clients can access the facility easily. The program can help by providing transportation and bus tokens, so that adolescents cannot use lack of transportation as an excuse for missing group sessions. Programs in rural communities may face the challenge of maintaining a functional group size (eight to ten clients). Rural providers may want to consider modifying the group schedule by offering the program on fewer days but for longer blocks of time. Also, curriculum from one group can be incorporated into other group sessions, which would cut down on the number of groups. Rural providers might also consider an all-day Saturday program (9 a.m. to 5 p.m.) with a parallel family program so that families need not make multiple trips to the facility. Another benefit to this approach is that by providing family programming at the same time, it could have the potential to increase parental involvement.

Programs need to maintain client flow to keep services financially feasible. One way to maintain client flow is to have staff give substance abuse assessments in the field. Chestnut has case managers that travel to detention centers, probation offices, child welfare agencies, and schools to do on-site assessments. By partnering with these organizations, CHS staff are able to assist in motivating adolescents to participate in treatment and assist with coordination of services. These collaborations also enable staff to develop working relationships with other professionals. It helps move clients through the system more quickly, which can increase the number of youth entering treatment.

References

Adams, L., & Wallace, J. L. (1994). Residential treatment for the ADHD adolescent substance abuser. *Journal of Child and Adolescent Substance Abuse, 4*, 35–44.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

American Society of Addiction Medicine. (2001). *Patient placement criteria for the treatment of substance related disorders* (2nd ed., Rev.). Chevy Chase, MD: Author.

Azrin, N. H., Donohue, B., Besalel, V. A., Kogan, E. S., & Acierno, R. (1994). Youth drug abuse treatment: A controlled outcome study. *Journal of Child and Adolescent Substance Abuse, 3*, 1-16.

Budman, S. H. (1994). *Treating time effectively. The first session in brief therapy. Program manual*. New York: Guilford.

Center for Substance Abuse Treatment. (1999). *Enhancing motivation for change in substance abuse treatment. Treatment Improvement Protocol (TIP) Series 35* (DHHS Publication No. SMA 01-3519). Rockville, MD: U.S. Department of Health and Human Services.

Chiauzzi, E. (1991). *Preventing relapse in the addictions: A biopsychosocial approach.* New York: Pergamon.

Daley, D. C., & Sproule, C. R. (1999). *Adolescent relapse prevention workbook*. Holms Beach, FL: Learning Publications, Inc.

Dennis, M. L., Dawud-Noursi, S., Muck, R. D., & McDermeit, M. (2003). The need for developing and evaluating adolescent treatment models. In S. J. Stevens & A. R. Morral (Eds.), *Adolescent substance abuse treatment in the United States: Exemplary models from a national evaluation study* (pp. 3–34). Binghamton, NY: Haworth Press.

Dennis, M. L., Godley, S. H., & Titus, J. (1999). Co-occurring psychiatric problems among adolescents: Variations by treatment, level of care, and gender. *TIE Communiqué, Fall 1999*, 5–8 and 16.

Dennis, M. L., Hristova, L., & Foss, M. (1999). *Special runs on Illinois' electronic DASA Automated Reporting and Tracking System (DARTS) data base on all publicly funded treatment for 154,255 patients served (68,264 unique individuals) for fiscal year 1997*

(7/96 to 6/97). Bloomington, IL: Chestnut Health Systems. (Done under NIDA Grant No. R01 DA11977)

Dennis, M. L., Titus, J. C., Diamond, G., Donaldson, J., Godley, S. H., Tims, F., et al. (2002). The Cannabis Youth Treatment (CYT) experiment: Rationale, study design, and analysis plans. *Addiction, 97*(1), S16–S34.

Dennis, M. L., Webber, R., White, W., Senay, E., Adams, L., Bokos, P., et al. (1996). *Global Appraisal of Individual Needs (GAIN) volume 1: Administration, scoring and interpretation*. Bloomington, IL: Lighthouse Institute, Chestnut Health Systems.

Ellis, A., McInerney, J. F., DiGiuseppe, R., & Yeager, R. J. (1988). *Rational-emotive therapy with alcoholics and substance abusers*. Elmsford, NY: Pergamon.

Epstein, J. F. (2002). *Substance dependence, abuse and treatment: Findings from the 2000 National Household Survey on Drug Abuse* (NHSDA Series A-16. DHHS Publication No. SMA 02-3642). Rockville, MD: Office of Applied Studies, Substance Abuse and Mental Health Services Administration.

Garner, B. R., Godley, S. H., & Funk, R. (2002). Evaluating admission alternatives in an outpatient substance abuse treatment program for adolescents. *Evaluation and Program Planning, 25*, 287–294.

Glasser, W. (1976). *Positive addiction*. New York: Harper and Row.

Glasser, W. (1992). Reality therapy. In J. F. Zeig (Ed.), *The evolution of psychotherapy: The second conference*. New York: Brunner/Mazel.

Godley, S. H., Funk, R., & McDermeit, M. (2001). Comparing outcomes of research- and best practice-based treatment protocols. In J. M. Herrell (Chair), *Effectiveness of outpatient treatment for adolescent substance abuse*. Symposium conducted at the 109th Annual Convention of the American Psychological Association, San Francisco.

Godley, S. H., Risberg, R. A., Adams, L., & Sodetz, A. (2003). Chestnut Health Systems' Bloomington outpatient and intensive outpatient program for adolescent substance abusers. In S. J. Stevens & A. R. Morral (Eds.), *Adolescent substance abuse treatment in the United States: Exemplary models from a national evaluation study* (pp. 57–80). Binghamton, NY: Haworth Press.

Hester, R. K., & Miller, W. R. (Eds.). (1989). *Handbook of alcoholism treatment approaches: Effective alternatives*. New York: Pergamon.

Jemmott, L. S., Jemmott, J. B., & McCaffree, K. A. (1999). *Be proud! Be responsible! Strategies to empower youth to reduce their risk of AIDS*. New York: Select Media.

Kaufman, E. (1994). Family therapy: Other drugs. In M. Galanter & H. D. Kleber (Eds.), *Textbook for substance abuse treatment* (pp. 331–348). Washington, DC: American Psychiatric Press.

Kazdin, A. E. (2000). *Behavior modification in applied settings* (6th ed.). Chicago: Dorsey Press.

Liddle, H. A., & Dakof, G. A. (1995). Family-based treatment for adolescent drug abuse: State of the science. In E. Rahdert & E. Czechowics (Eds.), *Adolescent drug abuse: Clinical assessment and therapeutic interventions* (DHHS Publication No. 95-3908, NIDA Research Monograph Series No. 156, pp. 218–254). Rockville, MD: National Institute on Drug Abuse.

Liddle, H. A., Rowe, C. L., Quille, T. J., Dakof, G. A., Mills, D. C., Sakran, E., et al. (2002). Transporting a research-based adolescent drug treatment into practice. *Journal of Substance Abuse Treatment, 22*, 231–243.

Miller, W. R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior*. New York: Guilford.

Prochaska, J. O., & DiClemente, C. (1984). *The transtheoretical approach: Crossing traditional boundaries of therapy*. Homewood, IL: Dow Jones/Irwin.

Risberg, R. A., & Funk, R. R. (2000). Evaluating the perceived helpfulness of a family night program for adolescent substance abusers. *Journal of Child and Adolescent Substance Abuse*, *10*(1), 51–67.

Risberg, R. A., Stevens, M. J., & Graybill, D. F. (1995). Validating the adolescent form of the Substance Abuse Subtle Screening Inventory. *Journal of Child and Adolescent Substance Abuse*, *44*(4), 25–41.

Rogers, C. R. (1951). *Client-centered therapy*. Boston: Houghton Mifflin.

Rogers, C. R. (1959). A theory of therapy, personality, and interpersonal relationships as developed in the client-centered framework. In S. Koch (Ed.), *Psychology: A study of a science*. New York: McGraw-Hill.

Sampl, S., & Kadden, R. (2001). *Motivational enhancement therapy and cognitive behavioral therapy for adolescent cannabis users: 5 sessions* (Cannabis Youth Treatment Series, Vol. 1, DHHS Publication No. SMA 01-3486). Rockville, MD: Center for Substance

Abuse Treatment, Substance Abuse and Mental Health Services Administration. Retrieved from http://www.chestnut.org/li/cyt/products/mcb5_cyt_v1.pdf

Stanton, M. D., & Shadish, W. R. (1997). Outcome, attrition, and family-couples treatment for drug abuse: A meta-analysis and review of the controlled, comparative studies. *Psychological Bulletin*, *122*(2), 170–191.

Steinglass, P. (1994). Family therapy: Alcohol. In M. Galanter & H. D. Kleber (Eds.), *Textbook of substance abuse treatment* (pp. 315–329). Washington, DC: American Psychiatric Press.

Walen, S. R., DiGiuseppe, R., & Dryden, W. (1992). *A practical guide to rational–emotive therapy*. New York: Oxford University Press.

White, W. L. (1990). *The culture of addiction and the culture of recovery*. Bloomington, IL: Lighthouse Training Institute.

Yankura, J., & Dryden, W. (1990). *Doing RET—Albert Ellis in action*. New York: Springer.

ATM Treatment Manual

Appendix A: Key Terms

ASAM--This is an acronym for American Society of Addiction Medicine. This national organization has developed criteria for determining the appropriate level of care for substance-related disorders in adolescents and adults. The use of these criteria are mandated by some states. According to the Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders-2 (PPC-2R; ASAM 2001), there are five levels of care for adolescents: early intervention, outpatient services, intensive outpatient/partial hospitalization services, residential/inpatient services, and medically managed intensive inpatient services. ASAM has developed admission, continued service, and discharge criteria for each level of care. There are six criteria "dimensions" or areas of concern that are utilized to determine adolescents' treatment needs and thus their appropriate level of care:

Dimension 1: Acute Intoxication and/or Withdrawal Potential
Dimension 2: Biomedical Conditions and Complications
Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complications
Dimension 4: Readiness to Change
Dimension 5: Relapse/Continued Use or Continued Problem Potential
Dimension 6: Recovery/Living Environment

CAF (Collateral Assessment Form)—This form is completed by parents, relatives, and other collaterals of the adolescent. The information obtained is used to assist in understanding whether and how the adolescent's behavior changes.

Case Manager—This person's job responsibilities include completing initial screenings over the telephone, conducting screening evaluations and writing biopsychosocial reports, maintaining working relationships with referral sources, maintaining contact with adolescents and their families who are on the waiting list for admission to residential treatment, and assisting in setting up aftercare services for those adolescents who are returning to their communities after completing residential treatment. Several case managers also lead skills groups at probation/detention facilities.

Continuing Education Units (CEU)—Both licensing and credentialing organizations require continuing education in order to maintain a license or certification. CEUs can be earned by attending seminars/trainings that are offered throughout the state. One CEU is earned for each actual hour of attendance (excluding any lunch and break time). This requirement offers some assurance that staff are qualified and knowledgeable to treat adolescents and their families.

Counseling groups—These groups provide opportunities for adolescents to learn about themselves, to understand how others perceive their behaviors and feelings, and to learn new strategies for dealing with difficulties. During these groups, adolescents are encouraged to identify issues relevant to their lives (perhaps an MTP goal). The therapist's role is to reinforce honesty, openness, and any positive strategies discussed by group members. Also, therapists are solution-focused and strive for fostering hope and confidence that adolescents can make behavioral, cognitive, and emotional changes.

Discharge Status (AP, ASA, ASR)—Adolescents are discharged or transferred with one of the following three dispositions: As Planned (AP), Against Staff Advice (ASA), or At Staff Request

(ASR). An AP discharge indicates that the adolescent has accomplished most, if not all, of the objectives in their treatment plan. An ASA discharge most commonly results when adolescents refuse to attend their scheduled groups (e.g., lack of contact). An ASR discharge is reserved for those adolescents who cannot maintain behavioral stability in the treatment setting; their disruptiveness is detrimental to the treatment of other adolescents. Transfers, whether to increase or decrease the intensity of treatment or change the focus of treatment (e.g., referral to a psychiatric facility or a long-term behavioral facility), are considered AP, assuming the adolescent is willing to follow through with the recommendation.

***Family Night*—**Family Night is a weekly, two-hour program for all CHS adolescents, their families, and any other person who is supportive of an adolescent's recovery process. The first hour of each Family Night is a presentation on a specific issue. Issues addressed include family rules, goals and objectives, adolescent development, drug education, relapse signs, denial, coping styles, enabling and detachment, parenting skills, and AIDS/HIV education. Adolescents do not attend the first hour. The second half of Family Night consists of group family counseling. Both the adolescents and family members participate in the counseling groups.

***Intensive Outpatient Treatment (IOP): Level II treatment*—**This level of treatment provides a more intensive level of care than OP. IOP involves nine to twelve hours of skills and counseling groups in addition to individual and family counseling. Although Day Treatment is even more intensive (generally at least 25 hours of treatment per week), this level of care is also considered Level II treatment. Day Treatment adolescents participate in a combination of residential and IOP groups. Treatment lengths for both IOP and Day treatment typically range from two to four weeks.

***Juvenile Detention Center (JDC)*—**This is a detention center/jail for adolescents. It is located in Normal, Illinois. While most of the incarcerated adolescents are from McLean County, the JDC also houses adolescents from surrounding counties. A CHS case manager evaluates every McLean County individual who is incarcerated at the JDC. The evaluation is very comprehensive and addresses substance abuse, mental health, medical, housing, financial, school, job, and other possible problem areas. When appropriate, adolescents are opened as CHS OP adolescents while they are still incarcerated. The case manager develops a treatment plan and meets regularly with the adolescent until he or she is released and can begin attending OP groups at CHS.

***Levels of Care*—**ASAM denotes five levels of care, and the treatments described in this manual are part of a program that has all but Level IV. The levels of care are:

Level 0.5:	Early Intervention
Level I:	Outpatient (OP)
Level II:	Intensive Outpatient (IOP)/Partial Hospitalization
Level III:	Medically Monitored Inpatient/Residential
Level IV.	Medically Managed Inpatient/Hospital

As adolescents' problems become more severe, they are more in need of a higher level of care. And conversely, as adolescents improve their life situation, they are transferred to a less

intensive level of care. Movement from one level to another is based on their progress or lack of progress on the goals in their treatment plan. Goals and objectives are founded on the adolescent's problem areas. All problem areas are subsumed under two or more of the six ASAM dimensions.

Master Treatment Plan (MTP)—This is a document that primary therapists develop for each adolescent. The MTP identifies the adolescent's problem areas, the specific goals and objectives that will be addressed with the adolescent while in treatment, and discharge planning. The six ASAM dimensions provide the framework for the specific objectives. The MTP should reflect the problem areas that were identified in the Integrated Biopsychosocial Assessment and the GAIN. MTPs are regularly reviewed with the adolescent. The adolescent should have a clear understanding of how to accomplish each goal and when he or she is expected to have the goal completed. MTPs relate an adolescent's problem areas or needs with specific objectives and intervention strategies to assist him or her in achieving certain life goals related to recovery.

Minnesota Multiple Personality Inventory-Adolescent (MMPI-A)—This assessment helps identify personal, social, and behavioral problems in adolescents. The MMPI-A contains adolescent-specific scales and other unique features designed to make the instrument especially appropriate for today's youth. By offering reports tailored to particular settings, this assessment helps provide relevant information to aid in problem identification, diagnosis, and treatment planning for youth

Outpatient Counselor Assistant—This individual is responsible for supervising outpatient and residential adolescents in the assignment of specific tasks, working with individual adolescents in assigned areas, and providing transportation for adolescents to and from appointments. This position is part-time and requires the individual to possess a valid driver's license.

Outpatient Treatment (OP): Level I treatment—This level of treatment provides a variety of programming opportunities designed to achieve permanent changes in the adolescent and family. OP involves eight or fewer hours of skills and counseling per week in addition to individual and family counseling. OP also includes adolescents who recently successfully completed residential treatment. These adolescents are typically placed in aftercare groups (three groups per week). Aftercare adolescents generally have additional community support such as AA/NA/CA, school activities, church activities, a job, etc. Treatment length ranges from two to six months.

Primary Counselor—This individual is responsible for assessment, diagnosis, treatment planning/implementation, and referral for adolescents and their families. He or she also facilitates individual, group, and family counseling. Typically, this individual has a master's degree and is licensed as a Licensed Clinical Professional Counselor (LCPC) or Licensed Clinical Social Worker (LCSW).

Quality Assurance (QA)—This process involves continuous monitoring of appropriate use of agency resources. This program is composed of a series of reviews conducted by various staff (e.g., records, supervisors) aimed at assuring that the necessary elements (e.g., signatures, paperwork, justification of a recommendation, documentation) are present.

Quality Improvement (QI)—This program is designed to provide ongoing feedback and review of programmatic and agency-wide policies and procedures that enhance the delivery of services. QI is a process required for accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Student Assistant Program (SAP)—This is an early intervention program that provides services to 22 schools in McLean County and the surrounding area. SAP specialists see any student for any concern. The specialists are also trained to complete substance abuse screenings when appropriate. In addition, adolescents from CHS that are attending or returning to a SAP school are referred to the SAP specialist for additional support.

Skills Groups—Skills groups are designed to teach adolescents the skills and information they need to live their lives without substances. Skills groups address anger management, emotions, communication, stress management, AA/NA, denial/resistance, decision making, drug education, relationships, leisure education, relapse prevention, developing a recovery lifestyle, self-esteem, and life skills. Because of the emotional and/or cognitive development of adolescents, many experiential techniques are used rather than straight lectures.

ATM Treatment Manual

Appendix B: Job Descriptions for Key Staff

JOB DESCRIPTION

TITLE: Case Manager—Bloomington

QUALIFICATIONS:

Master's degree in human services with demonstrated experience or knowledge in delivering case management services in the natural environment, or bachelor's degree in human services plus two years experience providing case management and assessment services. Understanding of substance abuse essential. Prior experience with adolescent populations desired.

REPORTS TO: Intake/Referral Relations Coordinator

SUPERVISES: Interns

DUTIES AND RESPONSIBILITIES:

1. Participate in all required staff development activities.

2. Participate in all required patient and program staff meetings.

3. Develop community resources to serve patients in primary service area.

4. Provide patient assessment, linking, planning, monitoring, advocacy, and support case management activities to youth and coordinating continuing care plans for residential clients.

5. Conduct pre-admission screenings (Level I and Level II) in a timely fashion, usually within two to three working days.

6. Provide all required patient and program documentation in a timely fashion.

7. Develop community resources and conduct meetings with major providers in assigned service area.

8. Be available to provide information related to specific referral sources.

9. Provide pre-admission contact/support for clients on residential programs waiting list (weekly with client/family and/or referral source).

10. Provide documentation and/or testimony for the courts.

11. Facilitate education (presentations/trainings)/skills groups on various topics as requested by both the outpatient and residential programs as well as the general public/community.

12. Complete assessments/admissions as needed for both residential and outpatient programs.

13. Make regular recommendations regarding the improvement of service with particular emphasis on audit studies and quality improvement.

14. Participate in program development activities to improve services to clients and community.

15. Other duties as assigned consistent with training and experience.

16. Maintain and protect confidentiality of all organizational information gained in the course of performing job responsibilities including, but not limited to, salary, financial, and client information.

SKILLS AND KNOWLEDGE REQUIRED:

The case manager must be thoroughly oriented toward and interested in providing case management activities in the patient's natural environment. He or she must be knowledgeable of all community resources and possess the interpersonal skills to help patients access these resources and conduct conferences and linkage meetings with representatives from these resources. Community organizational skills are useful to organize social and recreational alternatives for youth.

EVALUATION: Annually by the intake/referral relations coordinator

TERMS OF EMPLOYMENT: Regular appointment, full time

JOB DESCRIPTION

TITLE: Intake/Referral Relations Coordinator

BROAD BAND: Lead Professional/Supervisor

QUALIFICATIONS:

Master's degree in human services with demonstrated experience or knowledge in delivering case management services, or bachelor's degree in human services with certification. Understanding of substance abuse essential. Prior experience with adolescent populations desired. Supervisory and public relations experience desired.

REPORTS TO: Director of Youth Services

SUPERVISES: Case Manager
Program Development and Grant Consultant

DUTIES AND RESPONSIBILITIES:

1. Coordinate the Chestnut Health System intake process for all youth, including maintaining a schedule of appointments and assigning appointments/services to appropriate staff within a timely fashion (within 10 working days) and completion of required documentation.

2. Maintain a protocol for emergency referrals, interventions, screenings, assessments, and/or admissions.

3. Conduct and supervise initial screenings, assessments, and admissions of clients, including scheduling admission and monitoring the waiting list.

4. Maintain the daily census for the residential program (submit report weekly to MIS).

5. Provide training and one hour of supervision to assigned staff.

6. Monitor staff productivity (25 billable hours per week)

7. Provide staffing of cases and facilitation of weekly team meetings.

8. Maintain and supervise all required documentation of services provided with in the time lines established, including reviewing written staff reports.

9. Provide documentation and/or testimony for the courts.

10. Provide and supervise linking, planning, monitoring, advocacy, and support case management activities to youth (including coordination with Unit 5) and continuing care plans for residential clients.

11. Maintain relationships with referral agencies and coordinate referrals from those agencies.

12. Develop community resources and conduct meetings with major providers in assigned service area.

13. Facilitate and/or assign staff to conduct presentations/trainings and skills groups on various topics as requested by both the outpatient and residential programs as well as the general public/community.

14. Make regular recommendations regarding the improvement of service with particular emphasis on audit studies and quality improvement.

15. Participate in program development activities to improve services to clients and community, including research projects.

16. Maintain and protect confidentiality of all organizational information gained in the course of performing job responsibilities including, but not limited to, salary, financial, and client information.

17. Other duties as assigned consistent with training and experience.

SKILLS AND KNOWLEDGE REQUIRED:

The intake/referral relations coordinator must be knowledgeable or experienced in screening and assessing individuals for substance abuse problems, specifically DSM IV diagnosis and ASAM placement criteria. He or she must possess excellent verbal and written communication skills. Interpersonal skills are essential in developing community referrals and identifying resources for youth and their families. Organizational and time management as well as supervisory skills are essential.

EVALUATION: Annually by director of youth services

EMPLOYMENT STATUS: Regular appointment, full time

JOB DESCRIPTION

TITLE: Latino Youth Interventionist

QUALIFICATIONS:

Interest and the ability to work with youth and their families, particularly Latino youth. Bilingual in Spanish/English. Ability to communicate effectively at an individual, family, group, and community level. At least 21 years of age, with a valid Illinois driver's license. Licensed CD counselor or certified eligible.

REPORTS TO: Youth Outpatient Program Coordinator
Director of Youth Services

SUPERVISES: None

DUTIES AND RESPONSIBILITIES:

1. Ensure that Latino youth have access to substance abuse treatment services.

2. Provide outreach services (defining individual, family, or community needs and making appropriate referrals).

3. Network with community agencies that could function as support systems for Latino youth. This includes probation officers, schools, churches, recreation facilities, treatment facilities, etc.

4. Develop therapeutic/supportive relationships with all Latino CHS clients. The Latino youth interventionist functions as a support for these clients.

5. Complete screenings utilizing the Global Appraisal of Individual Needs (GAIN) in order to identify problem areas and determine appropriate referrals.

6. Provide post-treatment support for discharged CHS clients and assist in the coordination of all necessary services.

7. Lead outpatient skills groups and assist with other outpatient activities (e.g., supervising clients, urine screens, etc.).

8. Present drug information to community groups that include Latinos.

9. Provide interpretation services.

10. Conduct administrative functions such as monthly reports, screening reports, progress notes, etc.

11. Attend designated staff meetings.

12. Maintain a library of videos, books and treatment materials that are appropriate for Latino youth and their families.

13. Understand operational procedures for various safety equipment in the building.

14. Maintain and protect confidentiality of all organizational information gained in the course of performing job responsibilities including, but not limited to, salary, financial, and client information.

15. Provide transportation for clients to and from appointments and other agency functions.

16. Perform other duties as assigned.

EVALUATION: Annually by the outpatient program coordinator

TERMS OF EMPLOYMENT: Regular appointment, full time

JOB DESCRIPTION

TITLE: Youth Outpatient Coordinator

BROAD BAND: Lead Professional/Supervisor

QUALIFICATIONS:

Minimum of bachelor's degree with at least five years clinical experience and/or master's degree in psychology or social work with three years experience. Experience with substance abuse. Supervisory experience preferred.

REPORTS TO: Director for Youth Services

SUPERVISORS: Clinicians (Youth Outpatient)
Outpatient Counselors
Latino Youth Interventionist

DUTIES AND RESPONSIBILITIES:

1. Assist youth services director in activities as assigned.

2. Supervise staff, as assigned, including both clinical and paperwork activity.

3. Coordinate referrals and assessments and schedule residential and outpatient admissions.

4. Supervise treatment services as assigned.

5. Conduct staff meetings.

6. Provide staff training as assigned.

7. Provide recommendations for program development.

8. Provide on-call/back-up consultations as needed.

9. Prepare and present program reports as assigned.

10. Provide direct client treatment, including but not limited to assessments and individual, group, and family counseling when needed.

11. Maintain records of clients and the services provided.

12. Maintain and protect confidentiality of all organizational information gained in the course of performing job responsibilities including, but not limited to, salary, financial, and client information.

13. Other duties as assigned.

EVALUATION: Annually by the director of youth services

EMPLOYMENT STATUS: Regular appointment, full time

JOB DESCRIPTION

TITLE: Counselor Assistant

QUALIFICATIONS:

Interest in and the ability to work with youth. Ability to communicate. At least 21 years of age with valid Illinois driver's license.

REPORTS TO: Youth Outpatient Program Coordinator
Director for Youth Services

SUPERVISES: None

DUTIES AND RESPONSIBILITIES:

1. Supervise outpatient youth clients in the facility during designated hours according to the established schedule.

2. Provide specific group leadership skills as designated in the Comprehensive Rehabilitation Services to Youth.

3. Supervise residents in assignment of specific tasks during designated hours or as necessary to maintain facility in an appropriate manner.

4. Work with individual clients in assigned areas of responsibility under supervision of a designated staff member.

5. Maintain records of clients and services provided.

6. Attend designated staff meetings.

7. Assist in the coordination of all necessary services specified in the completed treatment plan for assigned clients.

8. Provide appropriate follow-up services as assigned.

9. Understand operational procedures of various safety equipment in the unit.

10. Maintain and protect confidentiality of all organizational information gained in the course of performing job responsibilities including, but not limited to, salary, financial, and client information.

11. Provide transportation for clients to and from appointments and other agency activities.

12. Perform other duties as assigned.

EVALUATION: Annually by the youth outpatient coordinator

TERMS OF EMPLOYMENT: Regular appointment, full time

JOB DESCRIPTION

TITLE: Youth Primary Counselor

QUALIFICATIONS:

Master's degree in counseling or clinical psychology, social work, or related field; or bachelor's degree with CADC certification and three years experience working in the field of substance abuse; or a non-degreed person with CADC certification and five years experience working with substance abusing youth and their families. Training in adolescent development preferred. Primaries must be licensed or certified, or be "license eligible." Three letters of recommendation from professionals in related fields are required.

REPORTS TO: Youth Residential Coordinator
Youth Outpatient Coordinator

DUTIES AND RESPONSIBILITIES:

1. Conduct initial screenings and assessment evaluations with adolescents ages 12 – 18 and their families; write biopsychosocial reports that address diagnosis and ASAM patient placement criteria.

2. Conduct admissions and develop individualized Master Treatment Plans.

3. Provide specific individual, group, and family counseling and rehabilitation services to clients and their families. Group work includes leading counseling groups and skills groups.

4. Maintain regular contact with each client's collaterals (i.e., probation, family, psychiatrist).

5. Maintain records of clients and all services provided (staffing, progress notes, telephone calls, reports), and complete in a timely manner (per CHS and state guidelines).

6. Attend and participate in all program and staff meetings, including weekly supervision.

7. Participate in program and staff development activities to improve services to clients and the community.

8. Provide court testimony when required.

9. Make regular recommendations regarding the improvement of services with particular emphasis on audit studies and quality improvement.

10. Be on call and provide backup duties for specific problems with clients.

11. Maintain and protect confidentiality of all organizational information gained in the course of performing job responsibilities including but not limited to salary, financial, and client information.

12. Other duties as assigned.

EVALUATION: Annually by the outpatient coordinator

TERMS OF EMPLOYMENT: Regular or temporary appointment, full or part time

The following checklist should provide you with the resources to learn your job and more fully understand the contents of this resource/training guide. By the end of your training period, you should have:

TRAINING TASKS

Observed the Following: (Within the 1st month of training) (See Supervisor for schedule of meetings)

_____ All-Staff Meeting (1)
_____ Outpatient Staff Meetings (8)
_____ Skills Groups (12)
_____ Counseling Groups (4)
_____ Assessments (2)
_____ Admissions (2)
_____ Attend weekly, one hour supervision with the Outpatient Coordinator (4)

Interviewed with:

_____ Loree Adams, Director of Youth Services
_____ Mychele Kenney, Residential Services Coordinator
_____ Rick Risberg, Outpatient Coordinator
_____ George Clark, Maintenance (to obtain keys and for driving company vehicles)
_____ Financial Counselor
_____ Outpatient Primary Counselor
_____ Outpatient Counselor

Viewed the Following Videos (complete a Training Report for each video)**:**

_____ Annual Safety & Infection Control
_____ Counseling ("Adolescent Treatment Approaches", "Assessment/Treatment Strategies)
_____ Cultural Sensitivity
_____ Huffing Series – 1994
_____ MMPI-A Implications – 1994 (for primary counselors)
_____ McLean County Child Abuse Prevention Network
_____ Parenting
_____ CHS Philosophy by Al Sodetz

Read the Following Manuals:

_____ New Employee Orientation Manual
_____ Policy Manual
_____ Safety Manual
_____ Youth Outpatient Services Handbook
_____ Time For Change (residential rules)
_____ Recreation Manual
_____ New Employee Orientation Manual
_____ Youth Outpatient Services Manual

Trained on the Following Paperwork (found in the Outpatient Program Services Manual)**:**

_____ SALs and how to complete SALs
_____ Weekly census
_____ Progress notes and how to write notes
_____ Documenting telephone calls and client/family/collaborative interactions
_____ Documenting telephone calls and insurance calls
_____ Incident Reports
_____ Assessment, admission, treatment plans, and discharge paperwork (primary counselor)

These above job tasks can be reviewed during supervision or be addressed during an interview with a primary counselor.

Trained on the Following Job Responsibilities:

_____ Urine Screens and BACs
_____ Driving CHS Vehicles

Medical (to be completed by the second week of employment):

_____ TB Shot **(must be completed prior to contact with clients)**
_____ Employee Health Questionnaire
_____ Seizure Control
_____ Incident Reports
_____ Interview with the nurse

Complete Assignments/Demonstrate Competency in the Following:

_____ #1 Personnel Policies
_____ #2 QI System
_____ #3 Safety & Infection Control
_____ #4 Theoretical Foundations & Philosophy
_____ #5 Patient Rights and Responsibilities
_____ #6 Overall Treatment Programming & Skills Development
_____ #7 Understanding Progression & Criteria for Abuse/Dependence
_____ #8 Assessment/Diagnosis
_____ #9 Treatment Planning/Treatment Goals
_____ #10 Staffings
_____ #11 Progress Notes
_____ #12 Group/Individual & Family Counseling
_____ #13 Skills Group Facilitation
_____ #14 Intervention Issues
_____ #15 Client Gray Books & Historical Files

- Primary counselors, case managers, and the Latino Youth Interventionist must complete assignments 1-15.
- Outpatient counselors must complete assignments 1-7 and 11-15. Tasks specific to the outpatient counselor will be reviewed in supervision.

STAFF: _____

EVALUATING OVERALL STAFF PERFORMANCE

All staff members are performance-evaluated at three months from their date of hire and each year from their date of hire. The supervisor completes an Employee Appraisal Report Form for each evaluation. This is then reviewed with the staff member, typically during supervision. Salary adjustments occur at the yearly evaluations and are determined by the performance of the staff member. An example of this form is on the following pages.

Assignment #1

PERSONNEL POLICIES

1. Identify and explain in writing the policies related to personal and professional conduct including:

    1. Use of alcohol/drugs
    2. Moral and legal community expectations
    3. Outside relationships with co-workers
    4. Credentials
    5. Appearance
    6. Staff/client relationships
    7. Dual relationships
    8. Secondary employment
    9. Client rights
    10. Sexual harassment/allegations of misconduct
    11. Interagency relationships

2. What are the policies regarding sick leave and vacations? How many vacation and personal days would an employee have after their first year of employment?

3. Describe the grievance procedure.

STAFF: _____

Assignment #2

QUALITY IMPROVEMENT

Read Section II of the CHS Policy Handbook. On a separate sheet of paper answer the following:

What is the continuous quality improvement system and what are some of the principles it is based upon? (Identify at least seven)

Name at least four of the current CQI teams.

What is the Utilization Review Program and who is responsible for conducting UR for youth residential services? List and briefly explain the six various components.

STAFF: _____

Assignment #3

SAFETY AND INFECTION/EXPOSURE CONTROL

Review Section III of the CHS Policy Handbook and the Safety and Infection Control Manual. On a separate sheet of paper, answer the following questions:

1. Who are the safety committee members at the King building?

2. Which risks of exposure category do you fall into and what does that mean?

3. What are four situations where an incident report should be filled out? What is an incident report, where are they found, who are they returned to, and what are they used for?

4. What should you do if you bring an electrical appliance to work for your office?

5. In case of fire, what do you do?

6. Where would you go during a tornado drill?

7. What are universal precautions in theory and practice?

8. Describe CHS policy regarding confidentiality of HIV status and testing.

9. Describe the procedures for dealing with seizures (see the nurse).

STAFF: _____

Assignment #4

CHS THEORETICAL FOUNDATIONS & PHILOSOPHY

Observe the in-service video entitled "Treatment Philosophy" by Al Sodetz. On a separate sheet of paper, identify the four theoretical foundations of CHS treatment philosophy. For each theory do the following:

1. Theoretical Foundations _____

2. What it means in your own words:

3. How we believe it helps our clients in their treatment/life/recovery:

4. Six specific ways (actual specific behaviors or statements) in which you can demonstrate this theoretical/therapeutic tenet to clients:

5. Three specific examples of behaviors or statements that contradict this theoretical foundation/therapeutic tenet:

6. An honest self-evaluation of your current ability to do this and what you need to help you do this better:

STAFF: _____

Assignment #5

PATIENT RIGHTS AND RESPONSIBILITIES

Read Section III of the Outpatient Program Services Manual. On a separate sheet of paper answer the following:

1. When are patient rights given to the patient?

2. How do we determine that the patient understands his/her rights?

3. What is confidentiality?

4. What are the exceptions which would allow us to violate a client's confidentiality?

5. How would you respond to a client who states that they have a grievance with CHS staff or CHS policies (see the CHS Policy Handbook)?

STAFF: _____

COMPETENCY CHECK/CHS POLICY

(To be filled out by Supervisor)

_____ has completed written assignments indicating their understanding of basic personnel policies, safety/infection control procedures, treatment philosophy and client rights/confidentiality.

DATE: _____

He/She has discussed client rights with their supervisor and is competent to communicate these rights to adolescent clients and their families and to respect these rights during the course of their employment.

DATE: _____

SUPERVISOR'S SIGNATURE: _____

STAFF: _____

Assignment #6

OVERALL TREATMENT PROGRAMMING & SKILLS DEVELOPMENT

Read Time For Change, view videos "Adolescent Treatment Approaches" (#78), "Treatment Philosophy" (#91), and "Deciphering and Using the Learning Domains" (#150 A & B) and complete interviews with Program Coordinators. On a separate sheet of paper answer the following questions:

1. CHS programming is a positive peer model. What does that mean?

2. Why does CHS consider this the best approach to working with adolescents and chemically dependent people?

3. CHS treatment programming is very group intensive. List the different groups clients may attend. For each write a 2-3 sentence summary that includes the following:

    a. the contents covered or what is addressed
    b. why this is a part of treatment or why chemically dependent adolescents need this
    c. how this will help clients in their life/recovery
    d. specific skills learned and how in your job you can help reinforce these skills

4. Describe the role and function of a peer leader.
    Why is it important for the program to have them?
    Why does being a good peer leader help the adolescent acquire needed recovery skills?

STAFF: _____

Assignment #7

UNDERSTANDING PROGRESSION AND CRITERIA FOR ABUSE AND DEPENDENCY

Review Sections II and III in the Outpatient Program Services Manual regarding Assessment, DSM-IV diagnosis and admission. Talk with your supervisor and other primary counselors. Observe assessments and/or screenings.

1. How does CHS determine if someone has a substance abuse problem?

2. Differentiate between use, abuse, and dependency.

3. A minority of residential clients do not meet dependency criteria. How are they different and in what ways do we/you need to approach them differently?

4. Put your answer to #1 and #2 into words you would say to a parent and to an adolescent client.

5. How can you respond to a client's or their parent's question about why others can/do use and they can't?

6. What is the CHS position on why people use?

7. What is denial?

8. Explain what is meant by "recovery" at a level that the person on the street, a new client or parent can understand.

9. What, if any, issues or difficulties do you anticipate associated with your past or present usage or recovery status and doing your job?

10. Thoroughly review/memorize DSM-IV criteria for chemical "abuse" and chemical "dependency."

STAFF: _____

Assignment #8

ASSESSMENT/DIAGNOSIS

Review Section II of the Outpatient Program Services Manual. Observe two assessments. Your supervisor will provide you with a copy of a completed and scored GAIN along with the profile sheet. Use this instrument to answer the following questions:

1. Client name _____
2. Client date of birth _____
3. Referral source _____

Using the GAIN, profile sheet, DSM-IV, and ASAM criteria, answer the following questions on a separate sheet of paper:

1. What five Axis diagnoses appear to be appropriate for this client?

2. Which level of care would be the most appropriate for this client and why?

3. Identify the needs that should be addressed with this client. Use the ASAM categories to categorize them areas to be addressed.

4. Are there additional concerns that this client has, that are not necessary for them to resolve in that particular level of care, but will need to be monitored?

5. How is "length of stay" determined? Why might the initial "projected length of stay" be extended or shortened?

6. Review at least three Assessment Summary reports.

7. Describe the typical referral process from a probation officer.

8. What is the difference between a Level I and a Level II referral?

STAFF: _____

COMPETENCY CHECK/ASSESSMENT-DIAGNOSIS

(To Be Completed By Supervisor)

_____ has observed at least three assessments.

DATE: _____

He/She has performed three assessments which were viewed by a qualified primary counselor or supervisor.

DATE: _____

He/She has completed written assignments and reading indicating an understanding of and competency in assessing adolescent client needs, making placement recommendations, and utilizing DSM IV diagnoses.

DATE: _____

He/She has demonstrated a working knowledge of the GAIN and how it leads to a diagnosis and treatment recommendations.

DATE: _____

He/She reviewed two completed Assessment Summary Reports with their supervisor.

DATE: _____

SUPERVISOR SIGNATURE: _____

STAFF: _____

Assignment #9A

TREATMENT PLANNING

Review Section III of the Outpatient Program Services Manual. You should also review several current client files, reading the Integrated Biopsychosocial Summary and the treatment plans. On a separate sheet of paper, answer the following:

1. Identify the purpose of the following sections of the treatment plan:

    a. Initial Treatment Plan

    b. Treatment Plan Part II

    c. Treatment Plan Part III

    d. Treatment Plan Part IV

2. When does the initial treatment plan get completed?

3. When is the Master Treatment Plan (MTP) to be in the file?

4. When are doctor's signatures required on the treatment plan (including the psychiatrist)?

5. How often must the treatment plan be reviewed with the client?

6. What is a "review" and how is it accomplished?

7. What documentation is required at the time of each review?

8. How is a MTP review documented on a SAL?

9. What are the ASAM Dimensions?

10. What is "manifested by"?

11. What is the difference between a "goal" and a "method" or "objective"?

12. Give examples of "special considerations" from Part III.

STAFF SIGNATURE: _____

STAFF: _____

Assignment #9B

ABC'S OF BASIC TREATMENT GOALS AND ACTIVITIES

The following are treatment goals/activities/expectations that most, if not all clients are expected to do/accomplish. Explain them (what they are and why clients are asked to do them) as you would to a client. Indicate about when (in the treatment stay) clients are most likely to do these.

a. Issues Lists
b. Drug History
c. Feelings Journal
d. Daily Meditation
e. Positive List
f. Get a sponsor
g. Gratitude List
h. AA Steps
i. Develop a Recovery Plan
j. Be more assertive
k. Identify their relapse signs
l. Understand their coping style
m. Talk more in groups
n. Identify the needs they met through using
o. Be a peer leader
p. Attend Family Night Program (clients and their families together)
q. Recognize how their thoughts affect their feelings and behaviors
r. Participate in family sessions

STAFF: _____

COMPETENCY CHECK/TREATMENT PLANNING

(To Be Filled Out By Supervisor)

_____, has completed written assignments, reviewed treatment plans, and reviewed goals indicating his/her understanding of the purpose of and procedure for treatment planning (assignments 9A and 9B).

DATE: _____

He/She has reviewed an existing treatment plan in supervision.

DATE: _____

He/She has completed an actual treatment plan with their supervisor which accurately reflects the client needs and methodology needed to address these.

DATE: _____

He/She appears to be competent to complete treatment planning for adolescent clients.

DATE: _____

SUPERVISOR SIGNATURE: _____

STAFF: _____

Assignment #10

STAFFINGS

Review Section III of the Outpatient Program Services Manual. Also refer to current client gray books. Use these sources to complete the following:

Summarize the various types of staffings. You should use a separate piece of paper. Specifically identify when an admit and MTPD staffing should be completed.

Supervisor's Signature: _____ Date: _____

List situations where a staffing form is required:

_____
_____
_____
_____
_____

Supervisor's Signature: _____ Date: _____

Complete staffing form for the following:

TYPE	SUPERVISOR'S INITIALS
Admission	_____
MTPD	_____
Progress/Promotion	_____
Discharge	_____

STAFF SIGNATURE: _____

STAFF: _____

COMPETENCY CHECK/STAFFING

(To Be Filled Out By Supervisor)

_____ has completed written assignments indicating his/her understanding of the purpose of staffings.

DATE: _____

He/She has observed a minimum of eight staff meetings.

DATE: _____

He/She is competent to conduct staffings for adolescent clients.

DATE: _____

SUPERVISOR'S SIGNATURE: _____

STAFF: _____

Assignment #11

PROGRESS NOTES

Review Section II of the Outpatient Program Services Manual addressing progress notes. Also review "Progress Note" sections of the current client gray books.

1. Find examples in current client gray books of the following notes:

TYPE	CLIENT NAME	DATE OF NOTE
Individual Session	_____	_____
Family Session	_____	_____
Family Group	_____	_____
Phone Call	_____	_____

Supervisor's Signature: _____ Date: _____

2. Complete examples of the following notes:

TYPE
Individual Session
Family Session
Family Group
Phone Call

SUPERVISOR'S SIGNATURE: _____ DATE: _____

STAFF: _____

COMPETENCY CHECK/PROGRESS NOTES

(To Be Filled Out by Supervisor)

_____ has completed written assignments related to the purpose of and procedure for completing progress notes.

DATE: _____

He/She has completed progress notes which were reviewed by their supervisor.

DATE: _____

He/She is competent to continue to complete written progress notes for adolescent clients.

DATE: _____

SUPERVISOR'S SIGNATURE: _____

STAFF: _____

Assignment #12

GROUP, INDIVIDUAL, & FAMILY COUNSELING

Co-Facilitate at least four Counseling/Gender Groups with another qualified primary counselor.

On a separate sheet of paper complete the following:

1. Describe your basic theoretical foundation when counseling adolescent clients and their families.

2. When might individual counseling be indicated?

3. Are there basic principles which you would adhere to when counseling adolescent clients and their families? Describe yours:

4. What are some basic "group" rules for facilitating counseling group?

STAFF SIGNATURE: _____

STAFF: _____

COMPETENCY CHECK/COUNSELING

(To Be Filled Out by Supervisor)

_____ has completed written assignments demonstrating his/her understanding of the basic counseling principles and an understanding of the purpose of individual, group, and family counseling.

DATE: _____

He/She has observed several counseling groups and has co-facilitated groups for at least one month of active participation, demonstrating their competence in counseling techniques.

DATE: _____

He/She participates in ongoing weekly supervision to discuss issues related to counseling and techniques.

SUPERVISOR'S SIGNATURE: _____

STAFF: _____

Assignment #13

SKILLS GROUPS

Read Section IV of the Outpatient Program Services Manual. Observe at least 12 different skills groups. Interview Susan Bunting (Coordinator of Curriculum and Instruction).

On a separate sheet of paper complete the following:

1. Identify the purpose of skills groups.

2. What are the different skills which are being taught?

3. Identify and define three different types of objectives which are to be met for each group.

STAFF: _____

COMPETENCY CHECK/COUNSELING

(To Be Filled Out by Supervisor)

_____ has completed written assignments indicating their knowledge of the purpose of skills groups and the procedures for using lesson plans and facilitating group.

DATE: _____

He/She has facilitated at least four different skills groups which were observed. They are able to teach the concepts given them, while managing the group. They are competent to facilitate groups.

SUPERVISOR'S SIGNATURE: _____

STAFF: _____

Assignment #14

WHAT TO SAY AND DO—INTERACTION AND INTERVENTION ISSUES

1. Warnings/Consequences
    a. Do's and don'ts: List at least three do's (therapeutic or positive ways) and three don'ts for intervening to warn a client who is misbehaving.
    b. What is the purpose of a consequence?
    c. How does a consequence differ from a punishment?
    d. Define and give an example of a Natural Consequence.
    e. Define and give an example of a Logical Consequence.
    f. Write five guidelines for developing/creating/giving effective consequences.

2. Power Struggles
    a. What is a power struggle?
    b. Why are they expected occurrences when working with children/adolescents?
    c. What action on your part increases the likelihood of or escalates power struggles involving you and a client?
    d. What actions on your part decrease the likelihood of or de-escalate power struggles involving you and a client?

3. Listening To and Paying Attention to Clients

Listening to and paying attention to clients are two of the most basic foundations that build a staff person's potential to be helpful/therapeutic. They are crucial in developing rapport, without which other interventions are quite ineffective.

    a. Write tens do's and don'ts for listening to/paying attention that fit all clients.
    b. Many of our clients have special needs related to listening and/or paying attention. Identify two special considerations for each of these groups of clients:
        1. ADHD clients
        2. New client
        3. Very needy clients
        4. Flirtatious clients
        5. Clients who are themselves poor listeners
    c. Define rapport
    Why is rapport important in your effectiveness with clients? (Try to tie in the CHS theoretical foundations.)
    List six general ways to build/increase rapport with these types of clients:
        1. Distrustful clients
        2. Anxious clients
        3. Clients with low self-esteem
        4. Aggressive clients
        5. Clients who "push your buttons" (clients you have trouble with)
    Are there any clients you have had difficulty with or expect to as far as developing rapport, and why?

4. Communication skills

How can your communication methods result in the following? Give at least two examples.

a. Increase negativity
b. Increase positivity
c. Build cohesion
d. Reduce tension
e. Redirect misbehaving clients
f. Make clients feel good about themselves
g. Make clients feel bad about themselves

What problems are likely to occur when staff (you or anyone) yell(s) across the unit? What can you do instead?

5. There are some very common opportunities to intervene that can make big differences. Below are some very common statements made by clients. Write a brief, but specific response (or two) that can help communicate important treatment beliefs/foundations/skills.
    a. You (or s/he) make me mad.
    b. I have to be here (in treatment).
    c. I don't have a problem (with alcohol/drugs).
    d. If marijuana was legal …
    e. I don't need treatment, now I want to quit and I didn't want to before.
    f. I don't have any issues/anything to talk about in groups.
    g. I want to use.
    h. Overheard war stories on the unit.
    i. You don't care.
    j. You're just here for the money.

STAFF: _____

COMPETENCY CHECK/CONSEQUENCES

I have reviewed the Outpatient Program Services Manual and observed groups. I understand how to give consequences and the rational for consequences. I have reviewed my understanding with my supervisor on _____. My supervisor has observed me giving a consequence on _____.

SUPERVISOR'S SIGNATURE: _____ DATE: _____

STAFF: _____

Assignment #15

NAVIGATING THE GRAY BOOKS AND HISTORICAL FILES (GBs AND HXs)

1. Explain each of the sections of the client Gray Books, and how you in your staff role would use it/them.

2. Tell what you could find out by reading each of the following from the client Gray Books:

    a. Initial "1-7" Tx Plan
    b. Master Tx Plan
    c. Consent to Tx
    d. Progress Notes
    e. Needs assessment/GAIN
    f. Assessment Update
    g. Disclosure Authorizations
    h. Staffing Forms

3. What is the client's Historical File and where is it?

4. What is the client Behavioral Contract and the Family Involvement Contract?

5. How would you know if there were any important special needs/treatment interventions orders for a client (i.e., suicide alert, special meds, learning disorder)?

STAFF: _____

COMPENTENCY CHECK RECORD

Gray Book Preparation

I have reviewed the Gray books for two therapists and understand the job expectancy in completely preparing Gray books. On _____ I prepared a Gray book for #_____ and reviewed this with my supervisor.

SUPERVISOR'S SIGNATURE: _____ DATE: _____

The next form is used for three-month and annual evaluations of all clinicians at Chestnut Health Systems. Following the Chestnut employee evaluation form is a more specific listing of the job functions required of Outpatient Primary Counselors. The latter document helps the supervisor and clinicians evaluate competencies.

Chestnut Health Systems

Clinical Competency Skills

Employee:_____ Supervisor: _____
Title: _____ Anniversary Date: _____(annual/3 month)

For each critical skill below, indicate if the employee meets (Yes or No) the competency for the skill and indicate the Evaluation Tool used to determine competency.

Evaluation tools:

1. Chart or Actual Documentation Review
2. Department Staff Meeting Minutes/Participation
3. Observation (including audio or video)
4. Demonstrates knowledge during supervision
5. Performance Improvement Data
6. Sample Documentation Review (not actual document)
7. Other (note in comment section)

Critical Skill	Meets	Evaluation Tool	Comments
Assessment			
1. Obtains accurate information to complete assessment.			
2. Evaluates diagnosis criteria in accordance with DSM-IV.			
3. Develops appropriate admission recommendations.			
Treatment Planning			
1. Ability to conceptualize interventions with appropriate theoretical models.			
2. Develops behavioral based treatment plans based on assessment that list problems, goal, and time frame for completion of objectives in collaboration with client.			
3. Treatment plans are developed and updated in a timely manner.			
4. Treatment plan contains appropriate continuing care plans (discharge plan).			
Individual and/or Group Psychotherapy			
1. Facilitates treatment in collaboration with client and family resources.			
2. Conducts counseling and skills groups.			

Critical Skill	Meets	Evaluation Tool	Comments
3. Able to demonstrate understanding and knowledge of materials being used in skills group.			
Confidentiality, Record keeping and Professionalism			
1. Maintains professional boundaries.			
2. Maintains record of all client services provided and completes in a timely manner (CHS and state guidelines).			
3. Maintains and protects confidential information.			
4. Complies with Universal Precaution and Infection Control Policies (Safety Training and TB Skin test).			
Substance Abuse Specific			
1. Demonstrates knowledge of physical, medical and pharmacological issues related to substance use and abuse.			
2. Educates client (and families) concerning special issues associated with Chemical Dependency treatment.			
3. Monitors emotional congruence and consistently addresses client's resistance in response to substance abuse education and counseling.			
4. Is knowledgeable of resources related to substance abuse referrals.			
Age Specific			
1. Demonstrates understanding of physical, cognitive, and psychosocial development of adolescents (ages 12 - 18).			
Other			

ISSUES TO WORK ON IN THE COMING YEAR

RATING OF GENERAL JOB PERFORMANCE ISSUES	**Rating Scale**
Reliability: Is on time and attends work in a consistent manner.	
Deadlines: Is consistent in meeting deadlines of the job, assignments are completed on time.	
Code of Ethics: Follows the established Code of Ethics.	
Supervision: Utilizes supervision in the established manner.	
Professional Growth: Is consistently working on own professional development and utilizes established training programs.	
Problem Solving: Makes suggestions to improve services and makes recommendations for changes.	
Policy and Procedures: Has working knowledge of the agency Policies and Procedures and actively follows these.	
Other Comments:	

Rating Scale

5- Exceptional; regularly exceeds expectations

4- Above average; sometimes exceeds expectations

3- Average; normally meets expectations

2- Below average; sometimes fails to meet expectations

1- Unsatisfactory; regularly fails to meet expectations

_____ I hereby concur with the above evaluation.

_____ I do not agree with the above evaluation and have attached a written statement regarding my disagreement.

Staff Signature: _____ Date: _____

Supervisor: _____ Date: _____

Human Resources: _____ Date: _____

Explanation of Evaluation Tools

The Clinical Competency Skills were assessed using the following objective evaluation tools.

1. **Chart of Actual Documentation Review**: Review a sample of client charts or documents for the presence of appropriate clinical information and documentation. The sample is limited to services provided during the year for which the evaluation is being conducted.
2. **Department Staff Meeting Minutes/Participation**: During the course of the year, staff members participate in a variety of clinical department and/or staff meetings. In these meetings, counselors discuss the clinical information, staff diagnoses, provide treatment plan updates and make treatment recommendations. The supervisor, as chairperson of these staff meetings, has direct opportunity to evaluate the performance of the counselor in these meetings as a means of assessing clinical competency.
3. **Observation (including audio or video):** Supervisors may observe a counselor engaged in therapeutic activities by direct observation or through review of taped observation (audio or video).
4. **Demonstrates Knowledge during Supervision**: During the course of individual and group supervision, a counselor may demonstrate their knowledge and competency. Supervisors may use the supervisory forum for directly assessing the competency of the counselor.
5. **Performance Improvement Data:** Throughout the year, various Performance Improvement measures such as Peer Review are conducted. This information can be used to evaluate the counselor. The data is limited to services provided during the year for which the evaluation is being conducted.
6. **Sample Documentation Review (not actual document):** During the training period and occasionally thereafter, a counselor may be asked to demonstrate their ability to perform a task through sample documentation. Whenever possible, actual documentation should be reviewed, however, in cases when actual documents are not available, a counselor's competency can be assessed through the use of a sample document. An example of this might be requesting the counselor to write a sample Progress Note to evaluate their ability to write behaviorally based progress notes.
7. **Other:** Supervisors have the discretion to use other evaluation tools in their objective measure of a counselor's competency. The tool should be noted in the Comment section of the form.

Job Title: Youth Primary Counselor

Job Description for the 12 Job Responsibilities/Work Functions

Work Function	Competency Evaluation Focus	Evaluation of Competencies
1. Conduct initial screenings and assessment evaluations with adolescents and their families; write bio-psychosocial reports that address diagnosis and ASAM patient placement criteria	**a.** Administer the GAIN-I accurately **b.** Identify client and family needs **c.** Accurately diagnose (DSM-IV) and make placement recommendations (ASAM) **d.** Demonstrate specific knowledge areas pertinent to adolescents and substance abuse (developmental, family, peer/gang, environment, comorbidity, educational, and abuse/neglect issues) **e.** Mandated reporting of abuse/neglect.	**Initial Evaluation Checks:** **a.** Read Training Manual information on assessment process and discuss in supervision **b.** Observe at least three assessments **c.** Complete two assessments observed by qualified staff, and write the Assessment Summaries **d.** Review Assessment Summaries in supervision to assess for accurate and objective information **e.** Demonstrates an integration of assessment results through the GAIN Dimensional Summary and clinical staffings **f.** Successful completion of Assessment Competencies **g.** Read, A Manuel for Mandated Reporters 1998, Illinois DCFS, and discuss in supervision 3 Month Evaluation: **a.** Completion of a through g (initial evaluation checks)
		Annual Evaluation: **a.** Continue review of above items **d** and **e** **b.** Adequate ratings in assessment-related areas from Peer Reviews

Work Function	Competency Evaluation Focus	Evaluation of Competencies
2. Conduct admissions and develop individualized Master Treatment Plans (MTP)	**a.** Admission process **b.** MTP development with individualized behavior-specific objectives, and out-come oriented goals and objectives **c.** Timeliness of MTP reviews **d.** Client involvement in MTP development and reviews **e.** Addressing any special needs (i.e., referrals for issues not being addressed at the client's current level of care, developmental/age issues, and special education issues) **f.** Discharge/aftercare planning	**Initial Evaluation Checks:** **a.** Review admission paperwork in supervision for first two clients; be observed completing an admit **b.** Review how to develop MTPs in supervision and review first two MTPs together in supervision **c.** Successful completion of Admission Training Competencies **d.** Successful completion of MTP Training Module **Annual Evaluation:** **a.** Continue review of above items **a** and **b** **b.** Supervisory review of all MTPs, Continuing Stay Reviews, and Discharge Reviews for documentation (progress notes) of client participation and accuracy of client's progress **c.** Adequate ratings in MTP related areas for Peer Review **d.** Demonstrate knowledge of community resources including substance abuse treatment, psychiatry, schools, self-help groups, probation, parole, etc. **e.** Written documentation/disclosures with involved service providers and the family/guardian and client **f.** When appropriate, have written documentation regarding helping clients and families follow through with referrals to other agencies (i.e., family counseling. GED, school, psychiatrist) **g.** Admission staffings and MTPs are timely and addressed with each client's unique needs **h.** MTP objectives are realistic, simple, clear, attainable, observable, and time-limited **i.** Adequate ratings in QI review of admission and MTP

Work Function	Competency Evaluation Focus	Evaluation of Competencies
3A. Provide Individual Counseling: Provide individual counseling and rehabilitation services to clients and their families	**a.** Knowledge of CHS theoretical foundation **b.** Understanding theories and techniques of counseling **c.** Knowledge of substance-related issues with the adolescent population **d.** Knowledge of developmental, cultural, and gender-specific issues **e.** Demonstrate respect and promote a safe environment	**Initial Evaluation Checks:** **a.** Successful completion of the C.H.S Theoretical Foundation Competencies **b.** Demonstrate the ability to appropriately utilize the theories of counseling **c.** Completion of course work or reading assignments addressing theories and techniques of counseling, addiction/recovery issues, and developmental issues **3 Month Evaluation:** **a.** Successful completion of the above (**a** through **c**) checks **Annual Evaluation:** **a.** Review client charts for documentation of individual sessions (at least 3 sessions) **b.** At least two hours of individual sessions each week (OPT) and 1 hour per week for residential clients **c.** Discuss individual sessions in supervision **d.** Supervisor will observe therapist interaction with clients for appropriateness

Work Function	Competency Evaluation Focus	Evaluation of Competencies
3B. Provide Group Counseling: Provide group counseling and rehabilitation services to clients and their families	**a.** Knowledge of group process and community issues (behavior problems, resistance to participating) **b.** Knowledge of developmental, cultural, and gender-specific issues	**Initial Evaluation Checks:** **a.** Successful completion of the Didactic Group Competencies **b.** Observe three counseling groups **c.** Lead two counseling groups observed by peers **3 Month Evaluation:** **a**. Successful completion of the above (a through c) checks. **Annual Evaluation:** **a.** Satisfactory ratings by group co-facilitators **b.** Lead weekly counseling groups **c.** Complete course work or reading assignments on group dynamics related to adolescent substance abuse **d.** In supervision, identify therapist strengths and weaknesses related to leading counseling groups **e.** Discuss in supervision any difficulties and successful interventions utilized in group counseling

Work Function	Competency Evaluation Focus	Evaluation of Competencies
3C. Lead Skills groups	**a.** Knowledge of group process and community issues (behavior problems, resistance to participating) **b.** Knowledge of group topics as related to adolescent substance abuse **c.** Knowledge of developmental, cultural, and gender-specific issues	**Initial Evaluation Checks:** **a.** Successful completion of Didactic group competencies **b.** Successful completion of community Self-help, and/or Counseling Group Competencies **c.** Observe three skills groups **d.** Lead two skills groups observed by peers and/or supervisor **3 Month Evaluation:** **a.** Successful completion of the above (a through d) checks. **Annual Evaluation:** **a.** Satisfactory ratings by group co-facilitators **b.** Lead weekly skills groups **c.** In supervision, regularly discuss what is effective and what is not effective in leading groups. **d.** Complete course work or reading assignments on the respective topics being presented.

Work Function	Competency Evaluation Focus	Evaluation of Competencies
3D. Provide family Counseling: Provide family counseling and rehabilitation services to clients and their families	**a.** Knowledge of family related issues with the adolescent substance abusing population **b.** Family involvement in each client's treatment	**Initial Evaluation Checks:** **a.** Successful completion of the Family Involvement Module **b.** Complete course work or reading assignments related to family therapy and ACOA issues with the substance abusing population **c.** Observe two family counseling sessions and process with the therapist **d.** Become familiar through reading and supervision of the Family Night Program. strongly encourage families to attend Family Night During the admit process **Annual Evaluation:** **a.** Average at least one hour of family counseling per week **b.** Review documentation for family sessions and maintain weekly contact with all client's families/guardians **c.** Review MTPs for inclusion of family goals

Work Function	Competency Evaluation Focus	Evaluation of Competencies
4. Maintain regular contact with each client's collaterals (i.e., probation, family, psychiatrist)	**a.** Contact with collaterals	**Initial Evaluation Checks:** **a.** Discuss in supervision importance of communication with collaterals on a regular basis **b.** Review documentation of contacts with collaterals. Maintain weekly contact with collaterals such as family, probation, and school **c.** Supervisor will contact collaterals (probation, referral sources) **Annual Evaluation:** **a.** Continue review of above items **b** and **c**
5. Maintain records of clients and all services provided (staffings, progress notes, telephone calls, reports) and complete in timely manner (per C.H.S, OASA and 2060 guidelines)	**a.** Documentation of all client related contacts **b.** SAL documentation **c.** ATM documentation and paperwork	**Initial Evaluation Checks:** **a.** Review at least two historical files **b.** Review two open files **c.** Read the SAL training booklet **d.** Turn SALS into supervisor each day for the first month for review **e.** Meet with ATM staff to discuss ATM procedures and paperwork **f.** Successful completion of Progress Note Competency **g.** Meet with Records Room staff for orientation **Annual Evaluation:** **a.** Supervisor will review five client files and SALS for appropriate documentation **b.** Documentation is completed in a timely manner (includes staffings, progress notes, telephone calls, Assessment and Discharge reports, SALS, and ATM paperwork)

Work Function	Competency Evaluation Focus	Evaluation of Competencies
6. Attend and participate in all program and staff meetings, including weekly supervision	**a.** Attendance at staff meetings **b.** Staffings **c.** Supervision	**Annual Evaluation:** **a.** Attend all scheduled staff and program meetings **b.** Regularly staff client's progress **c.** Utilize every staff meeting to seek information from other therapists regarding client/family interventions **d.** Attend at least one hour of direct supervision each week
7. Participate in program and staff development activities to improve services to clients and the community	**a.** Certification and licensure **b.** CEUs **c.** In-house training **d.** Safety issues	**Initial Evaluation Checks**: **a.** Successful completion of the Fire and Tornado alarm/drill competency. **b.** View the Safety/HIV video and complete the competency/training forms **Annual Evaluation:** **a.** Obtain certification (CADC) or licensure (LCPC; LCSW) as soon as possible, but no later than two years from date of hire **b.** Earn CEUs in order to obtain or maintain certification or licensure **c.** Participate in in-house training as deemed appropriate by supervisor: complete documentation verifying participation **d.** View the Safety/HIV video and complete the Training Report.

Work Function	Competency Evaluation	Evaluation of Competencies
8. Provide court testimony when required	**a.** Court testimony	**Annual Evaluation:** **a.** Read CHS procedures for giving testimony **b.** Discuss the process of giving court testimony with supervisor **c.** Appear in court and testify when required to do so
9. Make regular recommendations regarding the improvement of services with particular emphasis on audit studies and quality improvement	**a.** Improving the respective program, whether through direct client intervention or indirect (i.e., paperwork, makeup of groups) **b.** Knowledge about the CHS QI program and how and why audits are conducted	**Annual Evaluation:** **a.** Read CHS Manual related to the QI committee **b.** Demonstrate understanding of the process of making changes **c.** Regularly make suggestions regarding improvement in program in both staff meetings and supervision **d.** Complete Quality Improvement Competency
10. Be on-call and provide back-up duties for clients	**a.** On call duties	**Annual Evaluation:** **a.** When necessary provide crisis intervention services to clients at any time **b.** Notify supervisor of any crisis that may occur after work hours **c.** Talk with supervisor about how crises are handled after work hours

Work Function	Competency Evaluation Focus	Evaluation of Competencies
11. Maintain and protect confidentiality of all organizational information gained in the course of performing job responsibilities including, but not limited to salary, financial, and client information	**a.** Confidentiality	**Initial Evaluation Checks:** **a.** Demonstrate to supervisor an understanding of client confidentiality and the legal ramifications **b.** Review a Disclosure Authorization form with supervisor **c.** Discuss with supervisor the importance of maintaining organizational confidentiality **Annual Evaluation:** **a.** Maintaining and protecting confidentiality of all clients **b.** Disclosures and Client Rights forms are completed appropriately for all clients; supervisor will review client files **c.** No problems noted on client satisfaction surveys regarding confidentiality
12. Other duties as assigned	**a.** Completion of additional assigned duties by supervisor or director	**Annual Evaluation:** **a.** Level of willingness to complete additional duties as related to client or program needs

COUNSELOR EVALUATION OF SUPERVISOR

Suggested Use: The purposes are twofold: (1) to provide feedback for improving supervision and (2) to encourage communication between the supervisor and the counselor.

Supervisor: _____

Period covered _____ **to** _____

Directions: Circle the number which best represents how you, the counselor, feel about the supervision received. After the form is completed, the supervisor may suggest a meeting to discuss the supervision desired.

	Poor	Adequate	Good	NA
1. Gives time and energy in observing, supervising, consulting and case conferences.	1 2	3 4	5 6	X
2. Accepts and respects me as a person.	1 2	3 4	5 6	X
3. Recognizes and encourages further development of my strengths and capabilities.	1 2	3 4	5 6	X
4. Gives me useful feedback when I do something well.	1 2	3 4	5 6	X
5. Provides me the freedom to develop flexible and effective counseling styles.	1 2	3 4	5 6	X
6. Encourages and listens to my ideas and suggestions for developing my counseling skills.	1 2	3 4	5 6	X
7. Provides suggestions for developing my counseling skills.	1 2	3 4	5 6	X
8. Helps me to understand the implications and dynamics of the counseling approaches I use.	1 2	3 4	5 6	X
9. Encourages me to use new and different techniques when appropriate.	1 2	3 4	5 6	X
10. Encourages and lists to my ideas and suggestions for developing my counseling skills.	1 2	3 4	5 6	X

	Poor		Adequate		Good		NA
11. Helps me to define and achieve specific concrete goals for myself.	1	2	3	4	5	6	X
12. Gives me useful feedback when I do something wrong.	1	2	3	4	5	6	X
13. Allows me to discuss problems I encounter.	1	2	3	4	5	6	X
14. Pays attention to both me and my clients.	1	2	3	4	5	6	X
15. Focuses on both verbal and nonverbal behavior in me and in my clients.	1	2	3	4	5	6	X
16. Helps me define and maintain ethical behavior in counseling and case management.	1	2	3	4	5	6	X
17. Encourages me to engage in professional behavior.	1	2	3	4	5	6	X
18. Maintains confidentiality in material discussed in supervisory sessions.	1	2	3	4	5	6	X
19. Deal with both content and affect when supervising.	1	2	3	4	5	6	X
20. Focuses on the implications, consequences, and contingencies of specific behaviors in counseling and supervision.	1	2	3	4	5	6	X
21. Helps me organize relevant case data in planning goals and strategies for my clients.	1	2	3	4	5	6	X
22. Helps me to formulate a theoretically sound rationale of human behavior.	1	2	3	4	5	6	X
23. Offers resource information when I request or need it.	1	2	3	4	5	6	X
24. Helps me develop increased skills in critiquing and gaining insight from my counseling.	1	2	3	4	5	6	X
25. Allows and encourages me to evaluate myself.	1	2	3	4	5	6	X
26. Explains his/her criteria for evaluation clearly and in behavioral terms.	1	2	3	4	5	6	X
27. Applies his/her criteria fairly in evaluating my counseling performance.	1	2	3	4	5	6	X

ADDITIONAL COMMENTS AND/OR SUGGESTIONS

Signature *(Optional)* _____ Date: _____

ATM Treatment Manual

Appendix C: Materials for Skills Groups

RELATIONSHIPS GROUP #1

"Life Stories" Game

Activity:

Play Life Stories Game. Use this activity only if there are six or fewer clients in group. Not effective with larger groups.

Purpose:

To increase self-disclosure and group cohesion.

Materials Needed:

Life Stories Game
Table

Procedure:

1. Play the game.
2. Discuss thoughts and feelings related to the game.

FNDI Limited Partnership. 701 Decatur Avenue North, Suite 104, Golden Valley, Minnesota, 55327.

RELATIONSHIPS GROUP #1

Family Issue Question and Answers

Activity:

Clients will share responses to questions about family issues.

Purpose:

Clients will have the opportunity to process any significant family issues. They will increase their comfort level in sharing and exploring personal information with treatment peers.

Materials Needed:

List of questions.

Procedure:

1. Cut up the questions and fold each question in half. Place all questions in an open container.
2. Group members sit in a circle. Simply pass jar around and have client draw a question and answer it. *Allow as much time as needed for each member to think about and discuss their response.
3. Ask group members to provide feedback. See if anyone would like to answer same question.
4. Continue this process throughout group.

*Allow clients two "passes" in which they do not have to answer a particular question. Instruct them to draw another.

QUESTIONS for RELATIONSHIPS GROUP #1

What is your favorite memory with your mom?

What is your favorite memory with your dad?

What is a piece of advice that someone in your family has given that you remember?

Do you remember a time when one or both of your parents surprised you by something they did, said, asked of you, or believed in? Why did this surprise you?

Describe a time when you told a parent something that was difficult to share (you were afraid of what they would think or of consequences you would face).

Describe a time you said something to a parent that you wish you could take back.

Describe something a parent has said to you that you wish had never been said.

Describe a boundary or rule that is enforced in your home that you disagree with. How would you do it differently?

What is the topic of an argument that you have with one or both parents on a regular basis. How do your viewpoints differ?

In what ways do you manipulate your parents or siblings?

In what ways do you feel manipulated by parents or siblings?

Describe a relationship with an extended family member (aunt, uncle, grandparent, cousin) that is really important. What is important about that relationship?

How will you discipline your own child? Will you do the same things your parents do? How will your way be better or work better?

What is the most memorable thing your parent (s) have ever done for you?

In what ways are you like your mother? In what ways are you different?

In what ways are you like your father? In what ways are you different?

In 15 years, how do you think your relationship with your parent(s) will have changed? How would you like to see it change?

If your parent(s) were totally honest about their feelings about your behavior and usage, what would they say?

What would you like to say to your parent(s) about how you are working to make changes? What would you like them to know about your efforts or intentions?

What do you appreciate most about being part of your family?

RELATIONSHIPS GROUP #2

Usage within the Family

Activity:

Clients will view video on substance usage within the family and explore ideas related to such, including enabling, denial, and intervention. Introduce client to Alanon as a source of support.

Purpose:

Clients will explore issues of substance use within their own family, and discuss how this may have affected their own usage, their views about substance use, patterns of behavior within generations, and how "family secrets" are handled. Lastly, introduce ideas behind Alanon Program.

Materials Needed:

Video: "Elephant in the Living Room" Timothy Armstrong & Randall Frederick (Producers) & Timothy Armstrong (Director). (1991) Elephant In The Living Room [video]. (Available from FMS Productions, 1029 Cindy Lane, P.O. Box 50116, Capinteria, CA, 93014.)

Procedure:

1. Have clients watch video.
2. Discuss concepts: enabling, intervention, and denial.
3. Introduce concept of Alanon.

RELATIONSHIPS GROUP # 3

"Healthy" Family Conflict

Activity:

Clients will complete handout on healthy family conflict and process it with the group. In addition, they will discuss patterns of negative conflict.

Purpose:

Clients will examine conflict patterns in their family, and their role in such conflict. They will explore ways in which conflict becomes ingrained and/or escalates in families. Lastly, they will work on becoming comfortable sharing family difficulties in a group setting.

Materials Needed:

"Healthy Family Conflict" worksheet
Pencils
Writing board
Dry Erase markers

Procedure:

1. Introduce the idea of conflict and have clients generate their personal definition of conflict by writing it on the board.
2. Hand out family conflict worksheet and ask each client to complete it on his or her own.
3. Go around the room and ask each client to share three or four of their answers. Generate discussion based on client written responses.
4. Discuss how conflict can become escalated—
   - Body language
   - Personal space
   - Style of communication
5. Have clients discuss how they and their family participate in above behaviors.

HEALTHY FAMILY CONFLICT

1. What do we mean by “conflict”?

2. Who do you have the most conflicts with in your family?

3. What are the four things that cause the most conflict between you and family members?
   A.

   B.

   C.

   D.

4. List ways you deal with family conflicts:
   A.

   B.

   C.

5. Is there anything you would like to change about how you and your family handle conflicts? What?

6. What are some different ways you could deal with conflicts?

7. Was there ever a time when there were few conflicts in your family? What led to the increase in conflicts?

8. What would you change about your parents (or brother or sister) that would result in less conflicts?

9. What would you change about yourself if you <u>really</u> wanted to avoid conflicts with family members?

10. Will you try and talk with your parent(s) about how you might handle conflicts in the future? When?

RELATIONSHIP GROUP #4

Family Role Plays

Activity:

Clients will participate in role plays related to family issues and conflicts.

Purpose:

Increase assertive communication within the family system.

Materials Needed:

Role Play Scenarios

Procedure:

1. Divide the members into groups of two by counting off.
2. Have one group member out of each duo pick a slip with a role play situation. Let the duos confer for 2 – 6 minutes regarding how to play out the situation.
3. Have the two role play the situation without input from the rest of the group.
4. When the two are finished, solicit feedback from the other group members regarding:
   - Was the situation resolved in a satisfactory manner?
   - Has this situation ever happened to you?
   - What went wrong/right in the role-play?
   - What could the members have done differently to bring about a different conclusion?
5. Have each duo participate as time allows.

Note: Do not be afraid to help group members be creative or improvise with their role play situation. Example: If one group member gets stuck during a role play and another group member looks like they might want to take over, let them do the "tag-team" thing.

RELATIONSHIPS GROUP #4

(Copy and cut apart as needed)

Role Play #1

Member #1—You are a parent who has just discovered a bag in your teenage child's room, which contains several joints and a bottle of Jack Daniels. You are extremely concerned—how do you confront your child?

Member #2—You are the child in this situation—how do you respond to your parent's confrontation?

Role Play #2

Member #1—You are a teenager currently going through drug/alcohol rehab. You have decided that sobriety is very important to you. You have just learned that: (depending on gender of role-play partner) Female: your sister is pregnant or Male: your brother's girlfriend is pregnant. You know for a fact that the expectant mother uses frequently and heavily. This concerns you a great deal. How do you approach your sibling about it?

Member #2—Female: you are pregnant and currently using or Male: your girlfriend is pregnant and currently using. How do you respond to your sibling's confrontation?

Role Play #3—2 to 3 participants

Member #1—You are a teenager who is currently using heavily. You feel as if your have lost control of your life. You are ready to ask for help, but you know your parent(s) are going to completely freak when you tell them. How do you tell them?

Member #2 (#3)—you are the parent(s) of this teenager. You had no idea they were using. The thought that your child is using drugs and alcohol totally blows you away. How do you respond to your child while dealing with your feelings at the same time?

Role Play #4

Member #1—You are a teenager just out of residential treatment. You are doing everything you can to stay sober, but you are beginning to realize how difficult it is. At a family dinner an uncle/aunt pops open a beer and offers you one. You really want it. How do you handle the situation?

Member #2—You are the uncle/aunt in this situation. You have always given beer to your niece/nephew and you do not understand what the big deal is now. How do you respond to him/her?

Role Play #5

Member #1—You are a teenager just recently out of residential treatment. One day last week you skipped school to use with some old friends. You immediately realized what a mistake this relapse was and have gotten back on track. However, the school has contacted one of your parents and informed them you skipped. You confess to this parent what happened, but do not want the other parent to know. Even though you know secrets are unhealthy, you try to convince your parent to keep quiet about this.

Member #2—You are the parent in this situation. While your child was in residential treatment, you learned how unhealthy secrets are, but you have a long history of enabling your child. How do you respond now?

RELATIONSHIPS GROUP #5
Stereotypes

Activity:
Watch video and discuss.

Purpose:
To recognize that we are individuals and we should not judge others based on their race, how they dress, their sexuality, etc.

Materials Needed:
Video—"Stereotypes–What do you see?"

Procedure:
1. Watch video
2. Complete discussion questions

Rusty Kennedy (Producer) and Eli Reyna (Director). (1998) Stereotypes-What Do You See? [video]. (Available from Sunburst Communications, 101 Castleton Street, Pleasantville, NY, 10570)

DISCUSSION QUESTIONS

1. How would you define the term stereotype?

_____
_____
_____
_____

2. Describe your closest friends. Do people gravitate towards those of the same race? Why? Why not?

_____
_____
_____
_____

3. Describe a time when you were judgmental of someone based on the way the person looked, the way the person dressed….

_____
_____
_____
_____

4. Describe a time when someone was judgmental of you based on first impression? How did you feel?

_____
_____
_____
_____

5. What do you think about racism and violence?

_____
_____
_____
_____

6. What can you do to make a difference?

_____
_____
_____

RELATIONSHIPS GROUP #6
Differences

Activity:
Complete handout and discuss.

Purpose:
1. To help the clients recognize that people who are different from them can be some of their best teachers and can help them to expand.
2. To identify underdeveloped parts of themselves, which may need strengthening.

Materials Needed:
Handout and pencil: used with permission from Practical Techniques for Enhancing Self-Esteem, D. Frey & C. Carlock, (1991), pages 54 and 55. Modified by Kelli Maquet, M.S., LCPC

Procedure:
Complete the handout and discuss.

DIFFERENCES

1. Write the names of three people you know who are very different from you.

2. Describe how these people are different from you.

3. Pick one person from your list on whom to focus.

4. Imagine being that person. What would it be like?

5. Write at least three things that you could learn from that person.

RELATIONSHIPS GROUP #7

Respect: Keep it Real

Activity:

Watch video, complete handout and participate in discussion.

Purpose:

To understand and discuss the importance of having respect for others feelings, authority, and for self.

Materials Needed:

Video "Respect: Keep It Real", Jean Robbins & Ellin Holohan (Producers) & Director unknown. (1996) Respect: Keep it Real [video]. (Available from Sunburst Communications, 101 Castleton Street, Pleasantville, NY, 10570)
Handout
Pens

Procedure:

1. Watch video.
2. Answer questions after each segment of the video. Pause the video give clients a few minutes to jot down answers (use handout).
3. Discuss answers.
4. Answer additional questions on back of handout.

RESPECT: KEEP IT REAL

Part I: Respect for feelings (Victor and Latonya).

Part II: Respect for Authority (Wanda and Mr. Santiago).

Part III: Respect for self (Tony and others).

Write a definition of respect.

Why is respect important?

How do you show respect?

How is honesty related to respect?

RELATIONSHIPS GROUP #8
The Fourth "R": Responsibilities

Activity:
Watch video and participate in discussion

Purpose:
To understand the importance of behaving in a responsible manner and accepting responsibility for our actions.

Materials Needed:
Video "The Fourth "R": Responsibility"

Procedure:
1. Watch video
2. Answer questions and participate in discussion after each segment. Pause the video and allow a few minutes to discuss answers to the questions (There are four scenarios).

Susan Green & Ellin Holohan (Producers) & Director unknown. (1998). The Fourth "R": Responsibility [video]. (Available from Sunburst Communications, 101 Castleton Street, Pleasantville, NY, 10570).

RELATIONSHIPS GROUP #9

Love's Not Suppose To Hurt

Activity:

Complete dating violence quiz, watch part of the video, participate in discussion.

Purpose:

To educate on the problem of dating violence.

Materials Needed:

Quiz "What Do You Know About Dating Violence"
Video "Love's Not Suppose To Hurt"

Procedure:

1. Have the clients complete the quiz "What Do You Know About Dating Violence."
2. Watch the first skit in the video-Jake and Jenny.
3. Discussion.
4. Go over answers to the quiz.

Mumbleypeg Productions. (1996). "Love's Not Suppose To Hurt-Dating Violence". [video]. (Available from Corporate Alliance To End Partner Violence, 2416 E. Washington Street, Suite E, Bloomington, Illinois, 61704)

RELATIONSHIPS GROUP #10

Love's Not Suppose To Hurt

Activity:

Watch remainder of the video, participate in discussion.

Purpose:

To educate on the problem of dating violence.

Materials Needed:

Handout on types of abuse
Video "Love's Not Suppose To Hurt"

Procedure:

1. Watch the remainder of the video.
2. Discuss the video.
3. Discuss types of abuse.

Mumbleypeg Productions. (1996). "Love's Not Suppose To Hurt-Dating Violence". [video]. (Available from Corporate Alliance To End Partner Violence, 2416 E. Washington Street, Suite E, Bloomington, Illinois, 61704).

Types of Abuse

Physical Abuse—pushes or shoves you, slaps or hits you, pulls your hair, kicks or punches you, restrains you with force, chokes you, throws objects at you, abandons you in a dangerous place, grabs you roughly, twists your arm, takes "playful wrestling" too far, subjects you to reckless driving, threatens you with weapons.

Emotional Abuse—ignores your feelings, withholds approval, appreciation, or affection as punishment, continually criticizes you (calls you names, shouts at you), makes all decisions for you, wants to control all your actions, humiliates you in public or private, ridicules your most valued beliefs, your religion, your culture, your race/heritage.

Sexual Abuse—calls you sexual names, forces you to take off your clothing, touches you in ways that makes you feel uncomfortable, forces you to have sex against your will, minimizes the importance of your feelings about sex, accuses you of infidelity, withholds sexual affection to gain power over you.

RELATIONSHIPS GROUP #11
Healthy Relationships

Activity:
Watch video and discuss characteristics of a healthy relationship.

Purpose:
To identify what makes a healthy relationship.

Materials Needed:
Video "Relationships: When They Help…When They Hurt"

Procedure:
1. Watch the video.
2. While the clients watch the video, have each client write down one negative relationship they are in and its characteristics and one positive relationship they are in and the characteristics.
3. Discuss video and share negative and positive relationship.

Rebecca Goalby (Producer) and Susan Green (Executive Producer) and Ellin Holohan (Supervising Producer). (1997). Relationships: When They Help…When They Hurt. [video]. (Available from Sunburst Communications, Inc.)

RELATIONSHIPS GROUP #12

Evaluating a Friendship System

Activity:

Participate in answering discussion questions and complete poster.

Purpose:

To identify specific ways to strengthen friendships and understand how friendships influence in a positive and negative way.

Materials Needed:

Poster board, markers, colored pencils, possibly magazines, glue, and scissors

Procedure:

1. Answer discussion questions.
2. Create a poster including what makes a good friend.

DISCUSSION QUESTIONS

1. What qualities/values do you look for in a friend?

2. How do you know if you have a good friend?

3. What is your opinion regarding friends who use mood-altering substances or friends who engage in illegal activities?

4. How does who you choose as friends reflect how others see you?

5. What are some positive and negative ways that a friendship can influence you?

6. What are some changes you are willing to make regarding your friendship system?

Leisure Education Group #1

Activity:

Discussion regarding community resources.

Purpose:

To increase awareness of resources available in home community.

Materials Needed:

Bloomington/Normal Recreation Guide
Local telephone book
Handouts entitled "Community Agency Services and Information" and "Activities That May Interest You"
AA/NA meeting list

Procedure:

1. Review handouts entitled "Community Agency Services and Information" and "Activities That May Interest You."
2. Review Community access pages in front part of telephone book. Also review Human Services section (pp. 36–40).
3. Review Bloomington/Normal Recreation Guide and AA/NA meeting list.

This page is a placeholder for the handouts “Community Agency Services and Information” and “Activities That May Interest You,” which are not available electronically. For additional information, please contact Dr. Susan Harrington Godley at sgodley@chestnut.org or Richard A. Risberg at rrisberg@chestnut.org.

Leisure Education Group #2

Activity:

Play games, including table/board games, ping pong, foosball, or air hockey.

Purpose:

To promote having fun doing non-using activities and to promote healthy competition both individually and with a team.

Materials Needed: Board games, Ping-Pong table, foosball, air hockey, pool table, or games involving 2–4 people.

Procedure:

1. Review rules of conduct.
2. Help clients pick teams and games.
3. Review rules of games.
4. Whenever possible, staff can play the games with the clients or be part of a rotation (e.g., playing the winner of a ping pong game between 2 clients).
5. Play games or have a tournament with 1 or 2 games.
6. Discuss the possibility of clients continuing to be involved in these types of activities on a regular basis and how that might help their recovery.

Leisure Education Group #3

Activity:

Complete handouts and discuss.

Purpose:

To identify values regarding leisure activities and to identify present leisure habits and compare to leisure values.

Materials Needed: Handout titles, "Leisure Values"

Procedure:

A.
1. Discuss new challenging vocabulary.
2. Explain concept of balancing work, leisure, and self-care activities.
3. List one activity in the first box as an example. Check all qualities that have "attracted" or interested you in this activity.
4. Distribute handouts. Instruct the class to complete handout by identifying 6 leisure activities they enjoy, past and present.
5. Next, ask the class to check all qualities that "attract" them to or interest them in each of these activities.
6. Encourage them to write a paragraph describing the differences/similarities between their leisure habits and their leisure values, and answer remaining questions on handout.
7. Facilitate discussion regarding insights and process benefits of leisure environment.
8. Close by listing their responses to the last question.

B.
1. Write the 18 listed leisure qualities on separate index cards and shuffle.
2. Instruct students to take turns choosing a card and identifying on leisure activity they enjoy which has that quality. Continue until all 18 cards are discussed and/or every student has had a chance to participate.
3. Distribute handout and instruct class to complete.
4. Facilitate discussion regarding insights and process benefits of leisure involvement.
5. Close with discussion of their responses to the last questions.

Handout is from: Korb-Khalsa, K.L., & Leutenburg, E.A. (2000). Self-Esteem and Life Skills: 3rd in a series. (SEALS III). Beachwood, OH: Wellness Reproduction & Publishing.

This page is a placeholder for the handout “Leisure Values,” which is not available electronically. For additional information, please contact Dr. Susan Harrington Godley at sgodley@chestnut.org or Richard A. Risberg at rrisberg@chestnut.org.

Leisure Education Group #4

Activity: Gym activities.

Purpose: To promote good sportsmanship and group cohesion.

Materials Needed: Sports equipment located in equipment room.

Procedure:
1. Allow group members to choose activity.
Must be one in which all group members can participate (i.e. basketball, volleyball, etc.)
2. Facilitate playing the game.
Reinforce positive behaviors (i.e., good sportsmanship, positive conflict-resolution, etc.).

Leisure Education Group #5

Activity: Feeling charades.

Purpose: To increase ability to express feelings, self-disclosure, and group cohesion.

Materials Needed: Slips of paper with various feelings written on them, board markers, and small prizes

Procedure:
1. Explain the rules of charades.
2. Divide into two teams.
3. Play the game.
4. Winning team gets first pick of prizes. Everyone who played gets a prize.

Variation: Movie charades.

Leisure Education Group #6

Activity: Defining the term "leisure," completing handout, and discussing answers on handout.

Purpose: To enhance one's understanding of leisure and develop personal definitions of leisure.

Materials Needed: Handout titled "Defining Leisure"

Procedure:

A.
1. Present the concept of leisure. Emphasize the importance of leisure, and the value and benefits of having a well-rounded life.
2. Distribute handouts and pencils.
3. Ask students to complete top section, choosing one of the two questions to answer.
4. Discuss each student's response, listing the responses on a flipchart to be posted later.
5. Divide class into triads or small groups.
6. Give pairs 4-5 minutes to interview each other and record partner's responses to the five questions in bottom section of handout.
7. Reconvene and allow partners to introduce each other by sharing the most interesting response to one or two of the questions.
8. Post flipchart as a physical reminder of leisure "definitions." Refer to chart in future classes addressing leisure.

B.
1. Explain to class that the concept of leisure may be difficult to grasp. Bring to class several possible basic definitions of leisure written on index cards. For example: FREEDOM FROM RESPONSIBILITIES, GOING SNOWBOARDING, A "WANT TO" not a "HAVE TO," MY TIME, etc. Share definitions by asking students to read index cars to class.
2. Distribute handouts and pencils.
3. Give students 3-4 minutes to complete one of the two questions in the top section.
4. Have students divide into triads and share responses.
5. Emphasize that purposeful leisure is healthy and may assist in managing stress, provide exercise, decrease irritability, etc.
6. Give students 5 minutes to complete the bottom section.
7. Review the five questions in the bottom section, discussing the varied (and/or same) responses of class members.
8. Discuss with students what each learned from class discussion and offer observations of possible student insights regarding their leisure awareness, interests or style.

Handout is from: Korb-Khalsa, K.L., & Leutenburg, E.A. (2000). Self-Esteem and Life Skills: 3rd in a series. (SEALS III). Beachwood, OH: Wellness Reproduction & Publishing.

This page is a placeholder for the handout "Defining Leisure," which is not available electronically. For additional information, please contact Dr. Susan Harrington Godley at sgodley@chestnut.org or Richard A. Risberg at rrisberg@chestnut.org.

Leisure Education Group #7

Activity: Painting (paper or ceramic figurines).

Purpose: To promote self-expression, to promote non-using activities.

Materials Needed: Brushes, cups of water, newspaper, paint (for paper and/or figurines), ceramic figurines (if available).

Procedure:
1. Provide supplies and allow group members to choose what they would like to paint.
2. Share paintings.

—Allow time for clean-up.

Leisure Education Group #8

Activity: Journal creation.

Purpose: To promote self-expression.

Materials Needed: Construction paper, three hole punch, yarn, markers, pens, art supplies, instant camera from unit, ink pad

Procedure:

1. Introduce topic.
   - Group members will be making a book about themselves.
2. Instruct group members to put their book together.
   - Use three hole punch and yarn to bind the book.
   - Group members may decorate the outside to describe themselves.
3. Ideas for book pages.
   - Today's date.
   - My full name is _____.
   - My nickname is _____.
   - I was born on _____ in _____.
   - When I was born, I was _____ inches long and weighed _____ lbs. and _____ ounces.
   - Today I am _____ feet and _____ inches and weigh _____ lbs.
   - My hair is _____ and my eyes are _____.
   - May use camera for a picture of each group member.
   - May use ink pad for fingerprints.
   - Favorite things.
   - Family history, i.e., parents, siblings, pets.
   - Picture of home or bedroom.
   - Best friends.
   - Favorite activities.
   - Memories of childhood.
   - Favorite birthday.
   - Accomplishments.
   - Disappointments.
   - Goals or wishes for the future.
   - Predictions (i.e., "In five years I will be …").

Leisure Education Group #9

Activity: Leisure Wheel of Fortune game.

Purpose: To help clients identify leisure activities at CHS, in Bloomington/Normal area and the larger community.

Materials Needed: Wheel of Fortune spinner, pre-made word cards, chalkboard, erasers, pens and pencils

Procedure: Leisure Wheel of Fortune is a game that focuses on leisure resources through a guessing type game. There are several easy steps to follow to understand the process of the game:

1. There will be three to five participants.
2. Each player will spin to see who goes first.
3. Each word falls under one of three categories: facility resources, Bloomington/Normal area resources, and general community resources.
4. The first person will pick a category.
5. One word will be chosen by the leader and taped on the dry erase board.
6. The first person then spins again.
7. The participant then chooses a letter for that amount of money. For example, the person spins and it lands on $200, the individual can pick any letter except a vowel for the $200. Let's say they chose "h". If there is an "h", then that person will receive $200, if not they will remain at $0 or the balance at which before they spun the $200.
8. In order for a player to buy a vowel, they must have a cumulative total of $250.
9. This process continues to each participant or until someone solves the puzzle.
10. The person with the most money at the end of the game wins and advances to the bonus round.

The bonus round is where the winner has the chance to double their money. They once again chose their category, five consonants, and two vowels. The leader will then reveal what letters they picked are a part of the puzzle and tell the player that they have ten seconds to try and solve the remainder of the puzzle. If the player solves it then they have doubled their money and they will receive two prizes instead of one.

Variations:

1. If clients are unable to read or write, have the recreation staff or other clients assist them.
2. Instead of just using leisure resources words, use all different kinds of recreational activity words.
3. Instead of using the Wheel of Fortune word cards, just use the dry erase board (i.e., Hangman)

Leisure Education Group #10

Activity: Complete handouts and discussion of answers in handouts.

Purpose: To increase awareness of one's leisure participation patterns and to increase awareness of community resources that may support a person's recovery lifestyle.

Materials Needed: Handouts, "My Leisure Neighborhood" and "There Are Community Resources"

Procedure:

For "My Leisure Neighborhood" handout:

1. Before session, collect a variety of local resources: telephone directories, newsletters, newspapers, magazines, entertainment guides, radio listings, associations or organizations, volunteer opportunities, museum, gallery or lecture schedules, concerts, etc. Include sites that list community activities. In addition, provide one slip of paper for each student.
2. Discuss the meaning of a "community leisure resource" (anywhere that people participate in leisure activities in the community). Present information from GENERAL COMMENTS above. Direct class to create a list of local community leisure resources, e.g., malls, friends' houses, parks restaurants, gyms, museums, social clubs, etc.
3. Write list on board. Instruct class to classify resources according to the following leisure activity categories: Cultural, Outdoor, Relaxing, Social, Self-Discovery, Physical, spectator, Adventure, Creative Expression, Educational, Solo, Escape, Self-Confidence, Volunteer, etc. Discuss the possible motivation for participation along with benefits of each identified category.
4. Distribute slips of paper. Poll students as to which activity category they would like to participate in by writing their names and activity category on the paper.
5. Collect written results of poll. Sort by matching responses. Divide class into groups based on this information. Distribute handouts along with a selection of community information to each group.
6. Instruct students to create a list of events, dates, locations, equipment needed, weather conditions and possible expenses on appropriate symbol on handout. For example: PHYSICAL LEISURE – water symbol ice-skating or swimming, square: an athletic event, park symbol: hiking, house symbol: fitness video, etc. Encourage groups to locate opportunities available to them by searching listings of community resources if necessary. Encourage class to be creative yet practical. A request will be made to make a commitment to participate in one of the activities, either alone or with a small group, before the next class session. Allow ample time for research.
7. Reconvene class and share results of research, instructing students to note on handouts any new leisure resource that might be of interest. Encourage feedback from class.
8. Process by affirming students' commitments to participate in community leisure activity selected. Instruct class to be prepared to participate in a discussion about completed leisure activity during next scheduled class session.

For "There are Community Resources" handout:

1. Discuss new or challenging vocabulary.
2. Assemble several sets of current telephone directories. Consider the consumer (Yellow Pages) phone book, toll-free 800 numbers directory, federal, state, county or community directories. Also, local or statewide school systems, wellness or health network directories might be available. Check your library for almanacs, directories of organizations and associations, or The Address Book, and Who's Who. (There are many specialized editions such as Who's Who in Education or Who's Who in Support Services.)
3. Distribute handouts.
4. Divide the class into small groups. Give each group a set of directories.
5. Refresh their knowledge of using the index and proper subject headings in order to successfully use a telephone directory.
6. Instruct each group to use their directories to locate the names, addresses and phone numbers of resources available to them in each category of need listed on the chalkboard.
7. Reconvene as a class and ask one representative from each group to share from their list.
8. Facilitate:
    a. A discussion of telephone etiquette. Role-play using potential resources to practice phone-calling skills.
    b. A discussion of letter-writing techniques.
9. Ask the class to make one phone call or write a letter to one resource on their list before the next session. Inform them that they will be asked to provide feedback.
10. Close with a discussion of the availability and importance of community resources.

Handout is from: Korb-Khalsa, K.L., & Leutenburg, E.A. (2000). Self-Esteem and Life Skills: 3rd in a series. (SEALS III). Beachwood, OH: Wellness Reproduction & Publishing.

This page is a placeholder for the handouts “My Leisure Neighborhood,” and “There Are Community Resources,” which are not available electronically. For additional information, please contact Dr. Susan Harrington Godley at sgodley@chestnut.org or Richard A. Risberg at rrisberg@chestnut.org.

Leisure Education Group #11

Activity: Jeopardy game

Purpose: Drug/Alcohol education and to promote group cohesion.

Materials Needed: Board marker, Jeopardy Game Handout for group leader, small prizes.

Procedure:
1. Divide group into two groups.
2. Review rules of the game.
3. Play game.
4. Winning team gets first pick of prizes. Everyone who played gets a prize.

Leisure Education Group #12

Activity: Complete handout and discuss how leisure activities are an important part of the recovery process.

Purpose: To identify leisure activities in which one participates. To identify potential leisure activities for future participation. To identify the benefits derived from engaging in leisure activities.

Materials Needed: Handout titled "The Whole Benefits of Leisure Activities".

Procedure:

A. 1. Define the concept of a "whole you". Focus discussion towards impact of leisure activities upon a healthy lifestyle. Discuss benefits of leisure activities.

2. Distribute handouts. Encourage the clients to complete all, or most, of the 12 sentences using the context of being at school. Instruct students to list activities that they currently participate in to accomplish their leisure goals during unstructured times while at school. Possible responses might be "During lunchtime at school… A leisure activity I do to relax is reading… A leisure activity I do to compete is softball".
3. Allow 5-8 minutes for students to complete handouts.
4. Review responses, encouraging positive feedback from class. Instruct class to listen to peer responses, making additions to their own lists if necessary.
5. Instruct class to silently reread responses, placing a check in the box that best describes their current level of participation in that activity.

B. 1. Write 20-25 leisure activities on separate index cards and place face down in the middle of a desk or table.
   - Suggested activities might include: in-line skating, painting, shopping, board games, drawing, reading, doing crafts, photography, sports, exercise, volunteering, journalizing, composing e-mail, writing letters, gardening, clubs, scouting, dancing, listening to music, cooking, playing a musical instrument, talking on the phone, sewing, collecting, building models, martial arts, meditation, weight lifting or body training, massage, manicure, hair cut, dining out, swimming, learning new computer software, planning an event, fitness class or aerobics, performing community service, etc.
2. Instruct each client one at a time, to choose a card and say aloud the leisure activity.
3. Direct each student to choose a sentence with which they could match the selected card and complete the phrase. For example, if the selected card

lists “READING”, some participants might choose, An activity I do that “HELPS ME SPIRITUALLY” while others might choose “An activity I do TO BE ALONE”.

4. Distribute handouts.
5. Instruct the group to complete handouts based on personal experiences. Share results, encouraging positive feedback from the class. Permit changes or additions to the lists as needed.
6. Discuss how the same leisure activities can meet different needs, depending on interests and leisure lifestyles.
7. Process and include goal setting, by using check boxes provided on front of handouts as guidelines.

Because the average adolescent spends 6-7 hours in school daily, a large block of unstructured time remains. This time can provide a variety of opportunities for personal growth and development. Adolescence presents a vital opportunity for shaping enduring patterns of behavior that can set a young person on a healthy and successful course of life.

Some adolescents choose activities that increase confidence, teach teamwork, increase self-esteem, teach a sport or provide opportunities for spending time with friends. These activities have been shown to be linked to continued socialization, enhanced decision-making, improved problem solving, and reduction in boredom. Some teens use leisure time to counterbalance challenges and pressures in their lives.

Many adolescents, however, are reluctant to participate in activities that involve evaluation, criticism or judgment. They avoid activities that have the potential to create conflicts due to rules and structure, difficulty of quitting without guilt, or uncomfortable situations due to other participants.

By examining current available leisure opportunities, adolescents will be encouraged to develop lifelong positive attitudes and behavior changes toward leisure. Leisure education can make the connection between leisure satisfaction and life satisfaction.

Handout is from: Korb-Khalsa, K.L., & Leutenburg, E.A. (2000). Self-Esteem and Life Skills: 3rd in a series. (SEALS III). Beachwood, OH: Wellness Reproduction & Publishing.

This page is a placeholder for the handout "The Whole Benefits of Leisure Activities," which is not available electronically. For additional information, please contact Dr. Susan Harrington Godley at sgodley@chestnut.org or Richard A. Risberg at rrisberg@chestnut.org.

Leisure Education Group #13

Activity: Participants play a game called "A Matter of Values", then complete "Processing Questions" form.

Purpose: To assist clients in developing active listening skills. To assist clients in taking personal responsibility for leisure choices and outcomes. To assist the client in exploring the impact personal values and attitudes have on leisure experiences.

Materials needed: Attached activity form (different scenarios), pens/pencils

Procedure:

1. Remind clients that the person to whom a question is directed should be allowed to be the first to answer the question. Then others can give answers.
2. Read a question to a client and have the individual explain his or her answer. Then ask other group members if they would respond differently to the question.

A MATTER OF VALUES
ACTIVITY FORM

1. Would you be willing to participate in an afternoon of mud volleyball with your best clothes on for $40,000?

2. Would $50,000 be enough money to put a loyal healthy pet to sleep?

3. If you could prevent either an earthquake in a foreign country that would kill 40,000 people, a plane crash at the local airport that would kill 200 people, or an automobile accident that would kill an acquaintance of yours, which would you choose? What if the person were a close friend?

4. Would you rather be happy but slow to learn and unimaginative or unhappy yet bright and creative?

5. For $1,000,000 would you never see/talk to your best friend?

6. If you had to choose between a society without sport or a society without art, which would you choose?

7. If you could hold the title of world champion in any sport, what sport would it be?

8. Would you be willing to give up all television for the next five years if it would induce someone to provide for 1,000 starving children in a foreign country?

9. If you could have a leisurely four hour chat with anyone, living or dead, who would that be?

10. If you had $500 to either spend on a vacation, clothes, or on relatives, which would you choose?

11. If you could only learn one new leisure skill in the next five years, what skill would you like to learn?

12. If you were banished to a remote island with no other people residing there, what three non-living things would you take for your leisure time?

13. If you were notified that your home was going to burn to the ground tomorrow, what three things would you salvage today for your leisure time?

14. You are responsible for choosing one leisure activity to take into the next century for all humanity. What activity would you choose?

15. You are hired to give a parents' clinic on child-rearing. What one leisure value would you choose to tell the parents that they should teach their children?

PROCESSING QUESTIONS

NAME:

DATE:

1. What parts of the activity stood out for you?

2. What was the easiest part of the activity for you?

3. What was the hardest part of the activity for you?

4. What are you feeling as a result of the activity?

5. What awareness have you gained about yourself as a result of doing this activity?

SELF-ESTEEM GROUP #1
Introduction to self-esteem

Activity:
Complete handout, participate in discussion.

Purpose:
To define the term "self-esteem" and to explore clients' perception of their own level of self-esteem.

Materials Needed:
Handout "Self-Esteem Checklist" (used with permission from author)
Board Marker and Eraser

Procedure:
1. Discussion
   a. Review definitions of self-esteem.
   b. Ask participants to envision someone they know with high self-esteem.
   c. Write the characteristics on the board.
   d. Ask participants to envision someone they know with low self-esteem.
   e. Write the characteristics on the board.
   f. Discuss the differences – what affects someone's self-esteem level.
   g. Ask participants where they would place themselves.
   h. Discuss the relationship between self-esteem and substance use.

2. Complete self-esteem checklist.
   a. Consider "Almost Always" or "Often" answers to any of these questions as symptoms that may need improvement so as to enhance participants self-esteem.
   b. Have each participant choose one of the items from the checklist on which to improve.
   c. Have each participant identify realistic steps they will use to improve the behavior.

Frey, D. & Carlock, C. (1991). Practical Techniques for Enhancing Self-Esteem. Bristol, PA: Accelerated Development.

This page is a placeholder for the handout "Self-Esteem Checklist," which is not available electronically. For additional information, please contact Dr. Susan Harrington Godley at sgodley@chestnut.org or Richard A. Risberg at rrisberg@chestnut.org.

SELF-ESTEEM #2
Self-esteem Banner

Activity: Complete and discuss banner.

Purpose: To help acquaint individuals with the various aspects of self.

Materials Needed: Self-Esteem Banner handout (used with permission from author), markers, colored pencils

Procedure:

1. Recognize the concept of self-esteem banners and how banners have been used for centuries to symbolize and announce who a person was (for example, a lion in a banner meant strength).
2. Complete the banner—see diagram, write or draw responses in the nine areas.
   a. In area number one have each participant write or draw how he/she would like to be, his/her "ideal self".
   b. In area two have each participant write or draw what symbolizes the "real self".
   c. In area three have each participant write or draw what represents his/her fantasy self.
   d. In area four have each participant write or draw a representation of the "he/she" everybody knows, the "open self".
   e. In area five have each participant write or draw about the "he/she" hardly anyone knows, the "hidden self".
   f. In area six have each participant write or draw about things he/she is unsure of.
   g. In area seven have each participant write or draw about the things he/she does well, his/her "present self".
   h. In area eight have each participant write or draw about the things he/she would like to do well, his/her "self in process".
   i. In area nine have each participant write or draw one thing he/she would like to have said of him/her.
3. After completing the self-esteem banner, have each participant share their banner with group members by:
   a. anonymously posting the banners and having group members try to match banners with individuals. OR
   b. just share his/her banner, discuss with group members.
4. After each participant shares his/her banner, discuss the following:
   a. What kinds of things did each participant learn about himself/herself or things that cause him/her to wonder or to see himself/herself a little differently?
   b. What area of the banner was easiest to represent?
   c. What area of the banner was hardest to represent?

Frey, D. & Carlock, C. (1991). Practical Techniques for Enhancing Self-Esteem. Bristol, PA: Accelerated Development.

This page is a placeholder for the handout “Self-Esteem Banner,” which is not available electronically. For additional information, please contact Dr. Susan Harrington Godley at sgodley@chestnut.org or Richard A. Risberg at rrisberg@chestnut.org.

SELF-ESTEEM GROUP #3
Self-Esteem Bingo

Activity: Play self-esteem Bingo

Purpose: To help develop self-esteem and respect for others by giving positive feedback in a game format.

Materials Needed: One Bingo sheet for each person in the group (Materials used with permission from author)

Different numbers have to be put in each block, and each Bingo sheet should have numbers arranged differently. Under the E blocks may have numbers from 1 through 15; under S, numbers from 16 through 30; under T, numbers from 31 through 45; under EE, numbers 46 through 60; and under M, numbers 61 through 75. Example: Under the "E" column you might have 2, 14, 7, 10, and 5 on one card and 14, 10, 7, 6, and 2 on another card, etc.

The leader will need a master set of numbers from which to draw. Cut paper squares, numbered 1 through 75.

Each person will need approximately 20 markers to use when covering his/her blocks. Cut squares from construction paper or use paper clips, buttons, or other small objects.

Procedure:

1. Draw a number from a box containing the 75 squares with numbers.
2. Choose one of the following options:
   a. Option #1: pick a number and have each person with that number share his/her square. Continue until someone gets a line and calls out "Esteem". This method takes the most time.
   b. Option #2: pick a number and only periodically have the participants share their square. Example: "The next number I pick is a pass for everyone. Mark the square but don't share it." Then, "The next number I pick will be to share." Continue until someone has Esteem.
   c. Option #3: when someone gets Esteem, he or she stands up and says, "I Am A Worthy Person" and share all five of the squares.
3. If desired to do so, award suitable prizes.
4. Have a closing discussion.
   a. How did you feel about giving positive feedback to others during the game?
   b. If you received positive feedback from others during the game, what was that positive feedback?
   c. What positive things did you gain about yourself as a result of playing the game?
5. Please collect all cards and pieces and put in appropriate bags.

Frey, D. & Carlock, C. (1991). Practical Techniques for Enhancing Self- Esteem. Bristol, PA: Accelerated Development.

This page is a placeholder for the bingo sheet, which is not available electronically. For additional information, please contact Dr. Susan Harrington Godley at sgodley@chestnut.org or Richard A. Risberg at rrisberg@chestnut.org.

SELF-ESTEEM #4
Sentence Completion

Activity: Complete handout

Purpose: To increase self-awareness

Materials Needed:

Self-esteem Sentence Completion handout. (The majority of the items were used with permission from author); Modified by Chestnut Health Systems. Changes were made due to clients having difficulty completing some of the items.

Procedure:

1. Have each participant find a quiet place and complete as many sentences as possible.
2. Have each participant share responses that he/she is comfortable sharing – discuss.

Frey, D. & Carlock, C. 1991. Practical Techniques for Enhancing Self-Esteem. Bristol, PA: Accelerated Development.

SELF-ESTEEM SENTENCE COMPLETION

I like myself most when I…

_____
_____
_____

I like myself least when…

_____
_____
_____

My mother gave me a view of myself as…

_____
_____
_____

My father gave me a view of myself as…

_____
_____
_____

When I feel disliked…

_____
_____
_____

If I look at the criteria by which I judge myself…

_____
_____
_____

One of the things I can do to raise my self-esteem is…

_____
_____
_____

As I learn to accept myself…

_____
_____
_____

I am becoming aware…

_____
_____
_____

One thing I really like about myself is…

_____
_____
_____

Three things I am good at…

_____
_____
_____

The person who knows me best…

_____
_____
_____

I'm at my best with people when….

_____
_____
_____

I daydream about….

_____
_____
_____

Most people think that I…

_____
_____
_____

When others put me down…

_____
_____
_____

One thing that felt good about being drunk/high…

_____
_____
_____

When I think about being sober for the rest of my life I…

_____
_____
_____

If I could change one thing about myself I would…

_____
_____
_____

One thing that would surprise most people if they knew it about me…

_____
_____
_____

SELF-ESTEEM GROUP #5
Guided Imagery

Activity: Guided Imagery Exercise

Purpose: To practice relaxation strategies and to increase self-esteem.

Materials Needed: Art supplies and paper

Procedure:

1. Instruct clients to find a comfortable position in their chair or on the floor.
2. Lead clients through a deep muscle relaxation exercise.
3. Lead clients through guided imagery while in relaxed state.
   a. Option 1: envision how you would like your life to be.
   b. Option 2: envision that you are in a magical garden. Anything can happen.
4. Instruct clients to create an artistic representation of what they envisioned.
5. Allow clients to share and process.

SELF-ESTEEM GROUP #6
Values and Behavior

Activity: Discussion and completion of handout.

Purpose: To clarify values and explore the relationship between values and behavior.

Materials Needed: Paper and pens

Procedure:

1. Introduction/discussion questions
   a. What are values?
   b. Where do our values come from?
2. Have each participant list top ten values in first column:
   Example: family, honesty, sobriety, religion, freedom, health, wisdom, social approval, nature, career, etc. (leave space between each value).
3. What is the relationship between values and behavior? (behavior at home, school, work, at probation, with friends, etc).
4. In second column have each participant write how that value is displayed in his/her current behavior.
5. Discuss how values and behaviors changed over time. How will they continue to change?
6. In third column have each participant write about his/her old behavior in regards to that value and write how or what happened that they changed their behavior and the value became important to them.
7. On the back of his/her sheet have each participant write one behavior that he/she would like to change and how he/she plans on changing it? What value needs to become more important in his/her life?

SELF-ESTEEM GROUP #7
Strength Exchange

Activity: Give and receive strengths.

Purpose: To assist individuals to gain experience in giving and receiving positive feedback and to learn how perceptions of self match the perceptions of others.

Materials Needed: Paper and pencil.

Procedure:

1. Sit in a circle with one person at a time volunteering to sit in the middle of the circle.
2. Have each participant write three strengths he/she believes the person sitting in the middle has. (Allow no talking during this time.)
3. When all participants have finished their responses, give them to the volunteer in the middle of the circle.
4. Ask each volunteer to refrain from reading his or her feedback until everyone had a chance to sit in the middle of the circle.
5. Repeat the procedure until everyone has volunteered to be in the middle of the circle.
6. After everyone has received feedback about their personal strengths, have each participant write three strengths he/she believe he/she has.
7. Have each participant open his/her box or folder with the feedback in it.
8. Give each participant a chance to ask others questions about the feedback he/she received.
9. Discuss how his/her ideas about his/her strengths (responses to item 6) compare to those received from others.

Frey, D. & Carlock, C. (1991). Practical Techniques for Enhancing Self-Esteem. Bristol, PA: Accelerated Development.

SELF-ESTEEM #8
Esteem Building Inventory

Activity: Complete handout and participate in sharing and discussion.

Purpose: To emphasize the importance of a wide spectrum of positive resources in oneself, in others, and in activities.

Materials Needed: Pen and handout (Used with permission from author)

Procedure:
Complete handout and share responses.

Frey, D. & Carlock, C. 1991. Practical Techniques for Enhancing Self-Esteem. Bristol, PA: Accelerated Development.

QUESTIONS

1. List six aspects of your personality that you really like and are proud to let others see (examples: direct, loyal, creative, spontaneous, bright).
   a. _____
   b. _____
   c. _____
   d. _____
   e. _____
   f. _____

2. List ten of your favorite things to do (examples; gardening, reading, listening to music).
   a. _____
   b. _____
   c. _____
   d. _____
   e. _____
   f. _____
   g. _____
   h. _____
   i. _____
   j. _____

3. List five ways you support yourself emotionally (examples: weekly Men's/Women's group, regular dinners or lunches with friends with whom I can open up, personal growth group, regular vacations away, journal keeping).
   a. _____
   b. _____
   c. _____
   d. _____
   e. _____

4. List five ways you attend to your body (examples: racquetball and/or weight-training five times per week, hot tubbing, massages, regular physicals, relaxation exercises).
   a. _____
   b. _____
   c. _____
   d. _____
   e. _____

5. List four ways you attend to your spiritual like (examples: daily meditation, spiritual reading, spiritual discussions with friends).
   a. _____
   b. _____
   c. _____
   d. _____

6. List the people from each period of your life who taught you most about self-care and describe what each taught you (examples: Kerry—taught me to enjoy sports, Virginia—helped me to be gentler with myself and more forgiving).
   a. Childhood

   _____
   _____
   _____

   b. Adolescence

   _____
   _____
   _____

7. List the places where you have felt most relaxed, nurtured.

   _____
   _____
   _____

8. Describe your most powerful spiritual experience.

_____
_____
_____

9. List four ways you stimulate your intellect or creativity (examples: workshops, reading, joint work projects with friends).

a. _____
b. _____
c. _____
d. _____

10. Identify, by reviewing your answers, which areas you need to strengthen in order to more fully nurture yourself?

a. _____
b. _____
c. _____
d. _____

11. For each of two responses to Item 10, set one specific goal to further strengthen that area within the next month.

a. _____
_____
_____
b. _____
_____
_____
_____

WORKING RECOVERY #1

Where Are You in Your Recovery

Activity:

Clients will develop a treatment timeline exploring important times in their recovery and events leading up to it. They will discuss where they are individually in their recovery.

Purpose:

Clients will explore their own patterns of behavior in their recovery and how they have or have not changed over time. They will look at their current beliefs and attitudes about being in recovery and how their behavior may reflect these.

Materials Needed:

Large construction paper/Markers/Pencils/Dry Erase Markers

Procedure:

1. Hand out construction paper and markers.
2. Instruct clients to complete a detailed treatment timeline. Draw an example (see below) on board:

#1

TIMELINE – EVENTS

What got you into treatment initially	Successful discharge	Relapse	JDC after probation violations	Back in treatment	What goals are they working on	Where you see yourself in treatment	What level OP, IOPT, Residential

#2

TIMELINE – ATTITUDE/BELIEFS

How you felt when you started	How did attitude or belief change throughout all of these events?	Goal in attitude change

3. Remind clients that there will be two timelines. One looks at events and behaviors, the other looks at attitudes and beliefs. There needs to be a point on timeline #2 for every event noted on timeline #1. You may need to explain this a few times and offer extra help.
4. Have clients share their timelines and help them identify patterns in their behaviors.

WORKING RECOVERY #2

Dealing with using friends

Activity:

Clients will discuss how people influence each other and define "influence" versus "peer pressure". They will examine situations in which they have been influenced.

Purpose:

Clients will gain a better understanding of how they can and have been positively and negatively influenced by those around them. They will become more aware of how and when they are most susceptible to negative influences.

Materials Needed:

Dry Erase Marker/Paper/Markers

Procedure:

1. Discuss <u>how</u> people influence each other (clothing, music, language, sports, smoking, using).
2. Define "influence" versus "peer pressure".
3. Ask clients to share a time that they were influenced to use. If they are not able or willing to identify, ask them to discuss a time they were simply influenced to do something they knew could have a negative outcome.
4. Review discussion scenarios.
    a. Some friends are going to a party, <u>EVERYONE</u> will be there. You go, thinking you do not want to miss out. What goes through your mind? (CHS, parents, urine screens, probation). Can you really go without using?
    b. During lunch, some friends go into the bathroom and light up a joint. They ask you to join. What can you do? What should you do? What do you want to do?
    c. Ask clients for "Real Life" scenarios.
5. Do "incident drawings".
    a. Draw an incident with group in which you were using with friends.
    b. Share drawings and describe what were the consequences? Were there any benefits? How would you handle the situation today?

WORKING RECOVERY #3
Utilizing a Support Network

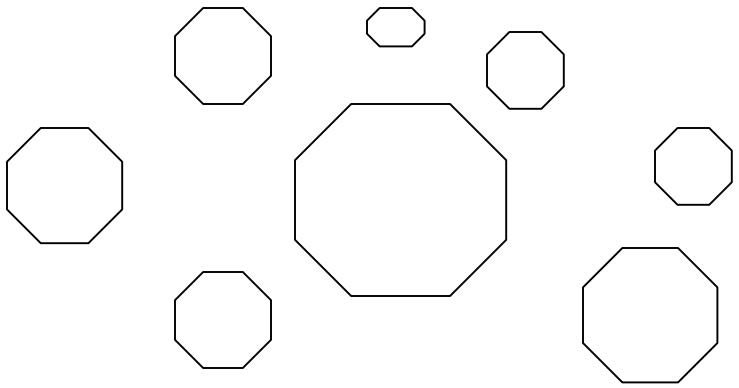
Activity: Clients will discuss important elements of an effective support network and examine their own network.

Purpose: Clients will explore the importance of a support network in their recovery. They will look at strengths and weaknesses in their own support system.

Materials Needed: Pencils/markers/large construction paper

Procedure:

1. Discuss term "support network"
   a. In recovery
   b. In daily/social life
   c. At school
   d. At home
2. Discuss what needs a support network fills. Ask the clients to share how they use their current network. Ask them to share a specific example.
3. Have clients name one person in their support network.
4. Have clients identify one person whose support network they might be a part of.
5. Give clients a piece of paper, and have them make a small list at the top of the page of five to ten people they have in their network. Use the list to make a chart:
   a. Draw a circle in the center of the paper, and have them put their name in it.
   b. Place members of support in smaller circles around center circle. Indicating by placement how close/distant/helpful each person is.
   c. Put red circle around users.
   d. Put blue circle around people your parents do not approve of
   e. Put green circle around people who have a history of legal trouble.
6. Discuss how thick or thin each person's network is. Recognize and acknowledge gaps and strengths.
7. Question clients on helpful support persons they may have left out.



WORKING RECOVERY #4

Dealing with a Habit

Activity:

Clients will discuss "SIDs" (Seemingly Irrelevant Decisions) (Monti et al., 1989) and discuss how they set themselves up for relapse and other significant problems. They will explore their ability to deal with such decisions and situations.

Purpose:

Clients will explore destructive patterns of thinking and behavior and look at how they may be putting themselves in risky situations. They will explore their ability to deal effectively with risky decisions and situations.

Materials Needed:

Dry Erase Marker/One copy: "Autobiography in Five Short Chapters" by Portia Nelson

Procedure:

1. Define SID (Monti et al., 1989).
2. Give some examples of SIDs.
   Examples:
   1. Going to a party with the intent to drink soda or just smoke cigarettes.
   2. Drinking non-alcohol beer "just for the taste".
   3. Making excuses to visit users or dealers ("I owe him," "I'm bored," "We're still friends").
   4. Hanging out with using friends.
3. Ask clients to take three to four minutes and think of a SID in their own life. Ask clients to share these with the groups. List some of the situations on the board.
4. Go through each one individually and ask the clients to rate their ability to deal with each on a scale of one to ten.
5. Read (don't hand out) poem to group.
6. Ask clients what it meant to them and how they might have related to it. Ask clients questions on poem page.

Monti, P.M., Abrams, D.B., Kadden, R.M., & Cooney, N.L. 1989. Treating Alcohol Dependence: A Coping Skills Training Guide. New York: Guilford.

AUTOBIOGRAPHY IN FIVE SHORT CHAPTERS

1) I walk down the street.
There is a deep hole in the sidewalk.
I fall in.
I am lost…I am hopeless.
It isn't my fault.
It takes forever to find a way out.
2) I walk down the same street.
There is a deep hole in the sidewalk.
I pretend I don't see it.
I fall in again.
I can't believe I am in the same place.
But it isn't my fault.
It still takes a long time to get out.
3) I walk down the same street.
There is a deep hole in the sidewalk.
I see it is there.
I still fall in…it's a habit.
My eyes are open.
I know where I am.
It is my fault.
I get out immediately.
4) I walk down the same street.
There is a deep hole in the sidewalk.
I walk around it.
5) I walk down another street.

Portia Nelson

READ THE POEM FIRST: then answer questions below or on back of this page.

1. Which "stage" are you at <u>now</u> (1, 2, 3, 4, or 5)? How do you know? Is it different for different problems in your life?
2. What are the "holes" that <u>you</u> tend to fall into?
3. What "streets" have you walked down that have been unhealthy for you?
4. What tools do you use to <u>keep you from</u> walking down the same street or falling into the same holes?

WORKING RECOVERY #5

The Use, Abuse, Recovery Game

*****Use only with groups numbering from 3–6 clients.

Activity:

Clients will play The Use, Abuse, Recovery game.

Purpose:

Clients will examine irrational thoughts and replace those thoughts with rational beliefs that will help them cope with the urge to use.

Materials Needed:

The Use, Abuse, Recovery Game

Procedure:

1. Speak with clients about using patterns that are influenced by individual thought patterns and beliefs. By focusing on changing self-defeating thoughts, clients are in a much better position to stop the cycle on thoughts of using.
2. Play game as directed.

The Use, Abuse, Recovery Game by LGR Productions, 3083 Main Street, East Troy, WI, 53120.

WORKING RECOVERY #5 (Alternative)
Future Stories

*****Use only with groups numbering from 3–6 clients.

Activity:
Clients will play "Future Stories" game.

Purpose:
Clients will increase their understanding of the importance of setting goals and making plans for the future.

Materials Needed:
Future Stories Game

Procedure:
1. Speak with clients about their view of the future and goals they have set for themselves (both short and long-term). Ask them if they see themselves doing anything specific in 5 to 10 years.
2. Play Future Stories as directed.

Future Stories (1992). Made by Talicot, Inc. 190 Gentry St., Ponima, CA. (800) 433-GAME

WORKING RECOVERY #6

Saying Goodbye to Addiction

Activity:

Clients will write a letter or journal entry letting go of their addiction and related behaviors and attitudes.

Purpose:

Clients will explore the issue of sobriety and recovery as a loss that they may grieve over. They will explore whether they each have said goodbye to their addiction since they have been in treatment and look at why this is important.

Materials Needed:

Pencils/Paper/Dry Erase Marker

Procedure:

1. Introduce concept of loss and grieving in relation to recovery and sobriety.
2. Have clients make a list on board of things they have given up (i.e., hobbies, recreational activities, friends, coping mechanism, identity, social opportunities).
3. Give clients a sheet of paper and pencil. Instruct them to write a letter saying goodbye to their addiction. Ask them to include:

(Write on board so clients can refer to it)

   a. What they have given up.
   b. What they have gained.
   c. How their outlook and attitudes have changed.
   d. Why they have to say goodbye.
   e. How they feel about saying goodbye.

4. Ask clients how they felt about writing the letter. Ask anyone who is comfortable to share his or her letter.

WORKING RECOVERY #7
Relapse Prevention

Activity:
Watch video "Relapse Prevention".

Purpose:
To help clients maintain sobriety and avoid a relapse.

Materials Needed:
Video "Relapse Prevention" 24 min.

Procedure:
Watch video and discuss.

CSR, Inc. (Producer) and Kate Milliarkis (Project Director). (1995). Relapse Prevention [video]. (Available from National Institute on Drug Abuse, P.O. Box 32652, Bethesda, MD 20824-0652).

WORKING RECOVERY #8

Recovery Plan

Activity:

Clients will develop a recovery plan by making a list of their needs met through using. They will identify signs of slipping and things that get them back on track.

Purpose:

To encourage group members to acknowledge reasons for using. Help clients find healthy ways to avoid using and develop appropriate coping skills.

Materials Needed:

Recovery Plan Handout. Pens, Markers, Paper.

Procedure:

1. Introduce the concept of a recovery plan and the importance of following the signs of recovery.
2. Have clients make lists of needs met through using.
3. Allow group time to share examples of their usage and encourage group feedback.
4. Draw recovery plan layout for group on the board for an example.
5. Have clients use the Recovery Plan handout for example and they will draw their own recovery plan.

This page is a placeholder for the handout "Recovery Plan," which is not available electronically. For additional information, please contact Dr. Susan Harrington Godley at sgodley@chestnut.org or Richard A. Risberg at rrisberg@chestnut.org.

WORKING RECOVERY #8 (Alternative)

Action Steps in Recovery

*2 full groups

Activity:

Clients will complete and process worksheets exploring action steps in recovery and watch video "Change Your Mind About Drinking and Drugs".

Purpose:

Clients will learn from others in recovery about daily challenges and specific "action" steps to make a recovery lifestyle workable. They will explore sources of positive support and look at how attitude affects behavior in recovery.

Worksheets:

Action Steps

Materials Needed:

Pencils/Video "Change Your Mind About Drinking and Drugs/TV, VCR

Procedure:

***NOTE**: This is a two-part group due to length of video (1 hour and 20 minutes). Plan on spending two group hours in order to complete.

1. Introduce the idea of specific action steps and how they are important in making lifestyle and behavioral/attitudinal changes.
2. Clients view video during entire first group and 1st half of second group (following week).
3. Process video with clients. Ask them how those in video have similar/different ideas and experiences from themselves.
4. Clients complete "Action Steps" worksheets and share answers with group.

ACTION STEPS – Answer these questions on your own, to the best of your ability.

1. List three things that you can do to help yourself when you want to use.
   1. _____
   2. _____
   3. _____
2. List three ways that you can ask your family for help.
   1. _____
   2. _____
   3. _____
3. List three ways that your family can help you in recovery.
   1. _____
   2. _____
   3. _____
4. List three ways that you can practice being open and honest.
   1. _____
   2. _____
   3. _____
5. List three things that you can do to help yourself follow rules.
   1. _____
   2. _____
   3. _____
6. List three things you can say to a friend who has drugs on them and wants to spend time with you.
   1. _____
   2. _____
   3. _____
7. List three ways that you help yourself deal with unpleasant feelings like sadness, anger, fear, worry, guilt.
   1. _____
   2. _____
   3. _____

If you find that you are really having a hard time answering these questions, ask your counseling group, gender group, or self-help for some ideas. Be sure to try to put your own answers first.

WORKING RECOVERY #9

Spirituality and "Higher Power"

Activity:

Clients will read (or listen to in a large group) a short story about acting "as if" and recognition of a Higher Power.

Purpose:

Clients will explore their own ideas of spirituality and how a Higher Power may assist them in recovery and other important life areas.

Worksheets:

Spirituality Handout

Materials Needed:

Pencils/Copies of short story

Procedure:

1. Introduce the idea of spirituality versus religion.
2. Ask clients to share how they explore or celebrate their own spiritual beliefs.
3. Read story to clients
4. Briefly process meaning of story to clients. Be sure to ask them if they have ever had similar experiences that they would like to share.
5. Have them complete worksheet addressing spirituality issues.
6. Renew worksheet and ask them to share their responses.

SPIRITUALITY HANDOUT

If you are unsure about the best Higher Power for you or if it can help, you can act as if. Pick the Higher Power that makes the most sense to you and act as if you believe in it. If your group is your Higher Power, do as they say even if you are not sure it will work.

If you think there is a Power who can help but you are not sure, you could pray. Your prayer can be "Higher Power, if you really exist, and if you care about me, please help me stay sober today and heal my spirit." Then listen and watch for answers, and act as if they will work. Depending on what Higher Power we find most helpful, our answers and help come in many ways.

One way our Higher Power often works is through other people. That is what happened to one man:

There is a story about a man whose home was in the path of a flood. As he stood on his front steps with water rising around him, a rescue squad came by in a boat. "Get in, we will save you," they said. "Thanks anyway," said the man, "but my Higher Power is going to save me." The boat went by.

The next day, as the man sat in his second story window, with water rising around his feet, another boat came by. "Come on, get in!" said the rescue team. "No thanks. My Higher Power is going to save me," said the man.

On the third day, as the man sat on his chimney dangling his toes in the water, a third rescue boat came to save the man. He still refused to get in the boat.

The man drowned.

In the afterlife, he met his Higher Power. He was a little angry, and said to his Higher Power, "I had faith in you and you let me down. For three days, I sat in a flood, waiting for you to save me. And look what I get from you! I'm dead!"

His Higher Power looked sadly at the man, shook his head, and said, "I wanted you to live, too! I sent three boats to save you, but you wouldn't accept my help."

—Author unknown

1. Write down the prayer written above that you can use if you are unsure about a Higher Power.

2. What does it mean to act as if?

3. What action could the man in the story have taken to receive the help his Higher Power sent?

4. What action could you take today to receive help from your Higher Power?

a.

b.

c.

(Hint: the prayer you wrote down in #1 could be one of them)

WORKING RECOVERY #10

Image

Activity:

Clients will complete treatment work on using and non-using image and process in group setting.

Purpose:

Clients will explore how they express their image and how it changed when they decided to quit using. They will look at their own perceptions of themselves and how they believe others see them. Lastly, they will look at how their goals have changed since they stopped using.

Worksheets:

"Image" Packet

Materials Needed:

Pencils/Dry Erase Marker

Procedure:

1. Have each client write their definition of "image' on the writing board.
2. Review each client's definition and discuss differences/similarities.
3. Have clients complete "image" packet. Remind them that each page needs to be thoroughly completed.
4. Go around group and ask each client to share 2-3 answers. Discuss each.

IMAGE

Describe yourself while you were using. What was your using "image"? Think of what you looked like, how you dressed, took care of yourself, how you acted, did you eat well, exercise?

How did people treat you while you were using?

Make a list of "goals" you have for yourself. These can include treatment goals, but also goals for when you leave treatment. What do you want for yourself?

How does (or could) your usage or your using image get in the way of your goals?

Describe yourself sober. What do you believe (and want) your "non-using image" to be? You can draw a picture of yourself as a collage if you would like to help describe yourself.

WORKING RECOVERY #11

Exercising Daily Changes

Activity:

Clients will complete a Daily Recovery Sheet and Exercises for Staying Straight Worksheet. Clients will discuss challenges to integrating recovery ideas into daily life.

Purpose:

Clients will explore how integrating new ideas and structure into their daily life may assist them in their recovery. In addition, they will discuss challenges to doing so.

Worksheets:

"Exercises for Staying Straight"
"Daily Recovery Checksheet"

Materials Needed:

Pencils

Procedure:

1. Ask each client to share one to two things they do each day to support their recovery.
2. Have them identify something they do that they know is not helpful to them in avoiding usage.
3. Have clients complete worksheets individually.
4. Go around room and have clients identify strengths and weaknesses in their daily plans. Ask clients to make suggestions to each other.
5. *Have clients individually commit to making one change to support their recovery in the next week.

*Don't forget to review this in the next week's group.

EXERCISES FOR STAYING STRAIGHT

Directions: As you know, it takes more than willpower to stay straight. Staying straight means learning new skills. The more of these skills that you have, the more successful you will become at living a full and healthy life. Circle items in the list below that you feel you need to improve. In this exercise, you want to get as much help and feedback from others as possible.

Fitness Resources

Stay away from the first drink
Get active
Use the serenity prayer
Go to AA meetings
Keep an open mind
Be patient
Do not test your willpower
Talk about your feelings
Speak your mind
Recognize your progress
Recognize your limitations
Give up control
Accept responsibility
Be honest
Structure your time
Maintain good eating habits
Believe in a Higher Power
Develop trust in others
Avoid complaining
Take the risk to change
Exercise
Change old routines
Find a sponsor
Stay rested
Avoid isolation
Share your happiness
Share your pain
Avoid resentments
Keep it simple
Have gratitude
Admit when you are wrong
One day at a time
Live and let live
Easy does it
Avoid self-pity
Ask for help
Don't judge others
Put sobriety #1
Be direct
Have fun
Offer help to others

CHALLENGE: Choose five difficult items and discuss them with your counselor or sponsor. Ask him or her how you can put each one into action.

ITEM	SUGGESTIONS
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Daily Recovery Checksheet

Today's Date _____

Today I have this many days in recovery _____

Two goals I will work on today are:
1. _____
2. _____

Appointment times today:

AA _____	I got 7-10 hours of sleep	Y	N
OPT _____	I ate breakfast	Y	N
PO _____	I ate lunch	Y	N
Work _____	I ate dinner	Y	N
FCC _____	I exercised by _____		
GED _____	_____		

I have used the following anger management skills today. (Put a check by each one used):

___ Worked on acceptance ___ Took time out

___ Stayed assertive ___ Read a book

___ Took a walk ___ Talked about feelings

___ TV/Radio ___ Took action to change the situation in a positive way

People I talked to about my recovery today:
1. _____
2. _____
3. _____

Today I lived Steps One, Two, and Three in this way: _____

_____

_____

Today I felt stressed about this: _____

And this is how I deal with it. _____

This worked: very well okay very little not at all

WORKING RECOVERY #12

Culture of Addiction/Recovery

*This activity works best with groups of nine or more.

Activity:

Clients will explore ideas of culture in relationships to recovery and ethnicity. They will look at similarities and differences between groups.

Purpose:

Clients will purposefully examine their own cultural beliefs and how they perceive others based on similar standards. They will come to better recognize and acknowledge the "Culture of Addiction and Recovery".

Materials Needed:

Cut-outs of: Red squares/Green triangles/Yellow circles

Procedure:

1. Hand clients <u>one</u> of the <u>three</u> cut-outs.
2. Have clients split into groups based on shape they have.
3. Assign each group an ethnic culture.
   (i.e.: △ = American, □ = African American, ◯ = Chinese)
4. Have each group brainstorm a list of how they are different from the other groups.
   INCLUDE: Food Rituals Values
   Religion Language Symbols
   Leisure Activities
5. Discuss the concept of "culture" and how these things define "culture".
6. Reassemble the group.
7. Put following grid on board with markers.
8.

Culture	**Addiction**	**Recovery**
List the cultural differences listed earlier during the activity		
i.e. food		
language		
symbols		

9. Discuss how cultural differences play out in the "addiction culture" or "using culture" and "recovery culture".
10. When list is complete, engage group members in discussion about moving from "using" culture to "recovery" culture.
11. Ask:
    a. "Which area must change for you to stay clean?"
    b. "How is recovery a way of life that will eventually touch all areas of life that addiction did?"

White, W. L. (1990). <u>The Culture of Recovery</u>. Bloomington, IL: Lighthouse Training Institute.

WORKING RECOVERY #12 (Alternative)

Holidays and Recovery

Activity:

Clients will complete handout related to issues of holiday celebrations, relapse, and coping skills. Further, they will complete a collage depicting how they feel about the holidays.

Materials Needed:

Art supplies (scissors/glue), old magazines, holiday handout

Purpose:

Encourage group members to acknowledge and discuss feelings related to important family holidays. Validate this as both a time of celebration and of difficulty, especially for those in recovery. Help clients recognize holidays as high risk situations and develop appropriate coping skills to allow them to successfully work through this time.

Procedure:

1. Introduce concept of relationship between holidays, recovery, and relapse.
2. Have clients complete handout related to holiday rituals and related emotions.
3. Allow clients time to share pieces of their responses in group. Encourage group feedback.
4. Allow clients access to art supplies.
5. Instruct clients to do a collage on each side of a piece of paper.
   Side 1: Depict in cut out pictures holidays of the past.
   Side 2: Depict in cut out pictures how you think holidays will/can be now that you have made positive changes.

HOLIDAY WORKSHEET

1. If you were to make a list of words that you associate with the holidays, what would they be:
   1. _____
   2. _____
   3. _____
   4. _____
   5. _____
   6. _____
   7. _____
   8. _____

2. How did your family celebrate the holidays when you were a young child?

3. Describe a typical family holiday celebration during the last two to three years at your house.

4. What family member typically organizes the holiday celebration?

5. What do you enjoy about your celebration traditions?

6. What would you like to do differently?

7. Do you associate any particular holiday with using drugs or alcohol? (example: New Year's Eve, Halloween, etc.)? Why do you make that association?

8. What will you be doing differently this year to avoid using?

LIFE SKILLS GROUP #1

Activity:

Treatment exercises and discussion related to nutrition.

Purpose:

To increase awareness of proper nutrition.

Materials Needed:

Handouts

"Food Guide Pyramid"

"Check Your Eating Habits" (Korb-Khalsa et al., 1992, p.37)

"Eating in Your Health" (Korb-Khalsa et al., 2000, p.39)

Pencils

Procedure:

1. Discuss what group members had to eat for the day.
2. Discuss Food Pyramid and make sample meal plan.
3. Complete worksheet "Check Your Eating Habits" and discuss.
4. Complete worksheet "Eating in Your Health" and discuss.

Korb-Khalsa, K.L., and Leutenberg, E.A. (2000). S.E.A.L.S. III Self-Esteem and Life Skills 3rd In a Series. Beachwood, OH: Wellness Reproductions and Publishing, Inc.

Korb-Khalsa, K.L., and Leutenberg, E.A. (1992). S.E.A.L.S. Plus Self-Esteem and Life Skills. Beachwood, OH: Wellness Reproductions and Publishing, Inc.

This page is a placeholder for the handouts “Food Guide Pyramid,” “Check Your Eating Habits,” and “Eating in Your Health,” which are not available electronically. For additional information, please contact Dr. Susan Harrington Godley at sgodley@chestnut.org or Richard A. Risberg at rrisberg@chestnut.org.

LIFE SKILLS GROUP #2

Activity:

Treatment exercises and discussion related to finances.

Purpose:

To increase awareness of money management.

Materials Needed:

Handouts

"Estimated Expense Record" (Chestnut Consumer Credit Counseling)

"Money Management"(Korb-Khalsa et al., 1992, p.41)

Calculator

Pencils

Procedure:

1. Discuss how clients typically spend their money.
2. Complete worksheet "Estimated Expense Record" and discuss.
3. Discuss how much a year you would need to be able to fulfill these needs.
4. Complete worksheet "Money Management" and identify the areas that clients need to work on.

Korb-Khalsa, K.L., and Leutenberg, E.A. (1992). S.E.A.L.S. Plus Self-Esteem and Life Skills. Beachwood, OH: Wellness Reproductions and Publishing, Inc.

This page is a placeholder for the handouts "Estimated Expense Record" and "Money Management," which are not available electronically. For additional information, please contact Dr. Susan Harrington Godley at sgodley@chestnut.org or Richard A. Risberg at rrisberg@chestnut.org.

LIFE SKILLS GROUP #3

Activity:

Treatment exercises and discussion related to employment.

Purpose:

To increase awareness of employment skills.

Materials Needed:

Handouts

"Getting Ready for Work" (Korb-Khalsa et al., 1996, p. 24)

"Starting Your Job Search" (Korb-Khalsa et al., 1996, p. 25)

Pencils

Procedure:

1. Discuss past/current job. What do they like/dislike.
2. Complete worksheet "Getting Ready for Work" and discuss.
3. Complete worksheet "Starting Your Job Search" and discuss.

Korb-Khalsa, K.L., Leutenberg, E.A., Azok, S.D. (1996). S.E.A.L.S. II Self-Esteem and Life Skills Too!. Beachwood, OH: Wellness Reproductions and Publishing, Inc.

This page is a placeholder for the handouts "Getting Ready for Work" and "Starting Your Job Search," which are not available electronically. For additional information, please contact Dr. Susan Harrington Godley at sgodley@chestnut.org or Richard A. Risberg at rrisberg@chestnut.org.

LIFE SKILLS GROUP #4

Activity:

Treatment exercises and discussion related to employment.

Purpose:

To increase awareness of employment skills.

Materials Needed:

Applications
Handouts
"A Better View of Interviews" (Korb-Khalsa et al., 1996, p.26)
Pencils

Procedure:

1. Complete application for employment.
2. Discuss need for correct spelling, neatness, handwriting, and names, dates, addresses, phone numbers for past employers and references.
3. Complete worksheet "A Better View of Interviews" and discuss.

Korb-Khalsa, K.L., Leutenberg, E.A., Azok, S.D. (1996). S.E.A.L.S. II Self-Esteem and Life Skills Too!. Beachwood, OH: Wellness Reproductions and Publishing, Inc.

This page is a placeholder for the handout "A Better View of Interviews," which is not available electronically. For additional information, please contact Dr. Susan Harrington Godley at sgodley@chestnut.org or Richard A. Risberg at rrisberg@chestnut.org.

LIFE SKILLS GROUP #5

Activity:

Guest speaker on employment.

Purpose:

To increase employment skills.

Materials Needed:

Guest Speaker From Chestnut Health Systems (CHS)

Rick Risberg
Loree Adams
Mychele Kenney

Procedure: Have guest speaker discuss interviews and how management and employees can deal with conflicts at work.

LIFE SKILLS GROUP #6

Activity:

Treatment exercises and discussion related to sexual decision-making.

Purpose:

To increase awareness of STDs.

Materials Needed:

Handouts

"Sexual Decision-Making" (Korb-Khalsa et al., 1996, p.62)

"Sexually Transmitted Diseases" (Developed by L. LaTurno, Chestnut Health Systems)

Pamphlet "STD Facts" and "STD: The Quiet Epidemic"

Pencils

Procedure:

1. Complete worksheet "Sexual Decision-Making" and discuss.
2. Complete worksheet "Sexually Transmitted Diseases" using pamphlets and discuss.

Korb-Khalsa, K.L., Leutenberg, E.A., Azok, S.D. (1996). S.E.A.L.S. II Self-Esteem and Life Skills Too!. Beachwood, OH: Wellness Reproductions and Publishing, Inc.

Global Protection Corporation. (1999). STD's: The Quiet Epidemic [Brochure]. Boston, MA: Author.

ETR Associates. (1986). STD Facts (2nd Edition). [Brochure]. Santa Cruz, CA: Hiatt, J., Clark, K., and Nelson, M.

This page is a placeholder for the handouts “Sexual Decision-Making,” “Sexually Transmitted Diseases,” “STD Facts,” and “STD: The Quiet Epidemic,” which are not available electronically. For additional information, please contact Dr. Susan Harrington Godley at sgodley@chestnut.org or Richard A. Risberg at rrisberg@chestnut.org.

LIFE SKILLS GROUP #7

Activity:

Treatment exercise and discussion related to personal legacy.

Purpose:

To increase awareness of personal goals.

Materials Needed:

Local Obituaries
Paper
Pencils

Procedure:

1. Have clients review various obituaries.
2. Discuss the differences and similarities among them such as: age, career, family, education, military history, interests, hobbies, and religious affiliations.
3. Have clients write their obituaries.
4. Have clients share and discuss what is important for them to be remembered for.

LIFE SKILLS GROUP #8

Activity:

Treatment exercises and discussion related to thankfulness.

Purpose:

To improve participants ability to express appreciation for other people.

Materials Needed:

Pencils
Markers
Pens
Stencils
Stickers
Construction paper

Procedure:

1. Make greeting cards for three people they are thankful for having in their lives. Cards should contain a statement explaining the reasons why they are thankful for that person.
2. Outside should be decorated to their liking.
3. Once cards are completed, all participants share their cards with the group.

Stumbo, N.J. (1999). Intervention Activities for At-Risk Youth. (pg. 298). State College, PA: Venture Publishing.

LIFE SKILLS GROUP #9

Activity:

Treatment exercises and discussion related to positive characteristics

Purpose:

To increase ability to verbalize positive characteristics about themselves and others.

Materials Needed:

Skittles
Lunch bags

Procedure:

1. Discuss goal of activity.
2. Have group form a circle.
3. For each color, participant is to follow the directions.
   Green—something nice about the person to your left
   Yellow—something you like about yourself
   Purple—something to do with friends
   Orange—something that you would like to be better at
   Red—something nice about the person to your right
4. Discuss how easy or difficult was it to come up with positive statements.
5. Why is it important to recognize the positive characteristics in yourself and others and what you can do to be more positive every day.

Stumbo, N.J. (1999). Intervention Activities for At-Risk Youth. (pg. 333). State College, PA: Venture Publishing.

LIFE SKILLS GROUP #10

Activity:

Treatment exercises and discussion related to positive characteristics.

Purpose:

To increase participants awareness of positive characteristics in themselves and others.

Materials Needed:

Poster Board
Magazines
Scissors
Glue
Markers
Colored Pencils
Crayons

Procedure:

1. Discuss the importance of positive qualities about yourself.
2. Discuss use of billboards.
3. Have client make their own billboard on themselves and discuss.
4. Share billboards after they are completed.
5. How difficult was it to determine what characteristics you wanted to share? What does your billboard say about you? What other positives could you have included on your billboard?

Stumbo, N.J. (1999). Intervention Activities for At-Risk Youth. (pg. 295). State College, PA: Venture Publishing.

LIFE SKILLS GROUP #11

Activity:

Treatment exercises and discussion related to fitness

Purpose:

To increase participants knowledge of various fitness activities and the importance of fitness in everyone's lifestyle.

Materials Needed:

Index cards with fitness words written on them

Procedure:

1. Put cards in a box or basket.
2. After selecting a card, the participant will act the exercise or type of fitness out until it is guessed.
3. After completing all the cards, participants will name four activities that were mentioned and will discuss these activities further.
4. Why is fitness important in our lives? What would happen if we didn't exercise? Can anyone name fitness exercises that we did not act out? Which fitness activities can be done alone? What are the benefits from exercising daily? Name one activity you can do everyday for fitness?

Stumbo, N.J. (1999). Intervention Activities for At-Risk Youth. (pg. 79). State College, PA: Venture Publishing.

LIFE SKILLS GROUP #12

Activity:

Treatment exercises and discussion related to positive aspects of healthy living.

Purpose:

To increase awareness of healthy living.

Materials Needed:

Large pieces of paper
Writing utensils

Procedure:

1. Discuss good things for our bodies.
2. Discuss bad things for our bodies.
3. Have participants make a body outline.
4. Participants put good things in the head and bad things outside the head.
5. Write everything that is good for the body on the inside of the body and everything that is bad for the body on the outside of the body.
6. Write everything that is good for the heart on the inside of the chest and everything that is bad for the heart on the outside of the chest.
7. Why is it important to keep bad things out of our body? Why is it important to keep good things in the body? What do you try to keep out of your body, mind, and heart?

Stumbo, N.J. (1999). Intervention Activities for At-Risk Youth. (pg. 75). State College, PA: Venture Publishing.